Coverage Appeals

This job aid provides information and guidance for Navigators and Certified Application Counselors (CACs), (collectively, Assisters) need to know to help consumers appeal a coverage decision made by their health insurance plan or issuer when serving consumers in the Federally facilitated Marketplaces (FFMs) – also known as the Health Insurance Marketplace®.

Note: This job aid provides information on health insurance issuer coverage 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 Marketplace eligibility appeals, refer to the Marketplace Appeals job aid.

Table of Contents

Version 4.0. October 2025. This information is intended only for the use of entities and individuals certified to serve as Navigators, certified application counselors, 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

Consumer Rights

If a health insurance plan denies a benefit, refuses to pay for a service that has already been received, or rescinds coverage, consumers can pursue options to change that decision. As described under the 2015 final rule for internal claims, appeals and external review, the Affordable Care Act (ACA) ensures a consumer's right to appeal their plan or issuer's coverage decisions.

If the plan or issuer upholds its initial denial decision, the consumer may be eligible for another review (known as external review) by an independent third-party reviewer.

Additionally, Section 110 of the No Surprises Act (NSA) expanded external review rights by:

- Making external review available for decisions that involve consideration of whether a plan or issuer is complying with patient cost-sharing and surprise billing protections under the NSA (i.e., NSA compliance matters); and

- Making external review of NSA compliance matters available to individuals enrolled in grandfathered health plans or coverage[i].

This expanded scope is applicable for claims as of January 1, 2022.[ii]

Benefit Determination

Benefit Determination Timeframes

A claim is any request for benefits, including pre-service (prior authorization) and post-service (reimbursement). Plans and issuers are required to make a benefit determination within an established timeframe.

Exhibit 1 lists the required timeframe for health insurance issuers to make a benefit decision depending on the type of claim.

Exhibit 1 – Benefit Determination Timeframes

Type of Claim	Benefit Determination Timeframe
Pre-service (prior authorization)	Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 calendar days
Post-service (reimbursement)	Within a reasonable period of time, but not later than 30 calendar days
Urgent care	As soon as possible, taking into account the medical exigencies, but not later than 72 hours

Adverse Benefit Determination

An adverse benefit determination (ABD) is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and any rescission of coverage.

When providing notice of ABDs, plans and issuers must:

- Provide information sufficient to identify the claim.
- Provide the diagnosis and treatment codes and their meanings.
- Describe reason(s), including denial code and its meaning, as well as a description of any standard used in denying the claim.
- Describe internal guidelines or criterion used in making the adverse determination; and inform the consumer that a copy of the internal requirements will be provided free of charge upon request.
- Describe reasons, including specific plan provisions or scientific or clinical judgment used.
- If the ABD is based on a medical necessity or experimental treatment or similar exclusion, provide either an explanation of the scientific or clinical judgment for the ABD, or that a notice that such explanation will be provided free of charge upon request.
- Provide a description of available internal appeals and external review processes, including how to initiate an appeal.

- Disclose the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsperson.

Culturally and Linguistically Appropriate Manner

When 10 percent of a county is literate only in the same non-English language(s), plans and issuers providing notices related to ABDs, appeals, and external reviews are required to provide for enrollees in that county:

- Oral language services and assistance with filing claims and appeals (including external review) in the applicable non-English language;
- Notices, upon request, in the applicable non-English language; and
- In English versions of notices, a statement prominently displayed in the applicable non-English language indicating how to access language services provided by the plan or issuer.

Types of Appeals

There are two types of appeals of a health plan decision:

- **Internal appeal.** If a consumer is appealing an eligible ABD, they may ask the insurance company to conduct a full and fair review of its decision. If the case is urgent, the insurance company must speed up this process.
    - Levels of internal appeal
        - Group market: A consumer enrolled in a group health plan may file one or two levels of appeal of an ABD prior to an external review.
        - Individual market: A consumer enrolled in an individual health plan may file only one appeal of an ABD prior to an external review.
- **External review.** If a consumer disagrees with an issuer's decision after an internal appeal, they can request an external review by an independent third party. This means that the insurance company no longer gets the final say over whether to pay a claim. An external review may be completed by either a state or a federal external review process.

Exhibit 2 describes who receives the appeal request for each type of appeal.

Exhibit 2 – What Entity Receives Appeal Requests

Process	Who Receives the Request
Internal appeals	▪ Health plan or issuer
External review – state process*	▪ State Department of Insurance, or ▪ State Department of Health, or ▪ Health plan or issuer
External review – federally administered process (in AL, FL, GA, TX, WI, American Samoa, Guam, Northern Mariana Islands, and Virgin Islands)	▪ Health plan or issuer, or ▪ The Department of Health and Human Services (HHS)-administered process contractor

* A list of the external review processes that apply to each state and territory.

Internal Appeals Process

There are three steps in the internal appeals process:

1. The consumer files a claim or a claim is submitted on the consumer's behalf.
2. The health plan denies the claim. The plan or issuer must notify the consumer in writing and explain why they denied the claim within the required timeframe, as described above.
3. The consumer files an internal appeal. To file an internal appeal, the consumer needs to:
    a. Complete all forms and processes required by their plan or issuer. The plan or issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
    b. Submit any additional information that the consumer wants the plan or issuer to consider, such as a letter from the doctor.

Note: The Consumer Assistance Program (CAP) in a consumer's state can file an appeal on the consumer's behalf. You can refer consumers to the "Important Information about Your Appeal Rights" section of their plan or issuer denial letter for additional instructions about how to designate an authorized representative.

Additional information on filing an appeal can be found at HealthCare.gov: Appealing a health plan decision.

Consumers can appeal the following determinations:

- The benefit isn't offered under the consumer's health plan.

- The consumer's medical problem began before they joined the plan. The consumer received health services from a health provider or facility that isn't in their plan's approved network.
- The requested service or treatment is "not medically necessary".
- The requested service or treatment is an "experimental" or "investigative" treatment.
- The consumer is no longer enrolled or eligible to be enrolled in the health plan.
- The issuer is canceling or discontinuing the consumer's coverage going back to the date they enrolled because the plan or issuer claims that the consumer did something that constitutes fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

A consumer has 180 days from receipt of denial to file an internal appeal. Consumers should generally file an appeal in writing. However, if the appeal is urgent, an oral appeal is acceptable. When filing an appeal, consumers should keep copies of all information related to the claim and the denial, including the documents described in Exhibit 3. When asked to submit information to the plan or issuer, consumers should keep original documents and submit copies to the insurance company.

Exhibit 3 – Internal Appeals Process Determination

Internal Appeals Process Documentation	
▪ The Explanation of Benefits (EOB) forms or letters showing what payment or services were denied. ▪ A copy of the request for an internal appeal sent by the plan or issuer. ▪ Any documents with additional information sent to the plan or issuer (like a letter or other information from a doctor).	▪ A copy of any letter or form a consumer is required to sign if they choose to have their doctor or anyone else file an appeal for them. ▪ Notes and dates from any phone conversations a consumer has with their plan, issuer, or their doctor that relate to the appeal. Include the date, time, name, and title of the person they talked to and details about the conversation.

At the end of the internal appeals process, the plan or issuer must provide the consumer with a written decision. If the plan or issuer still denies the service or payment for a service, the consumer can ask for an external review. The plan or issuer's final determination must include instructions on how the consumer can ask for an external review. (For more information on external reviews, refer to External Review Process Overview.)

Exhibit 4 lists the timeline for issuers to make an internal appeals decision based on the appeal type.

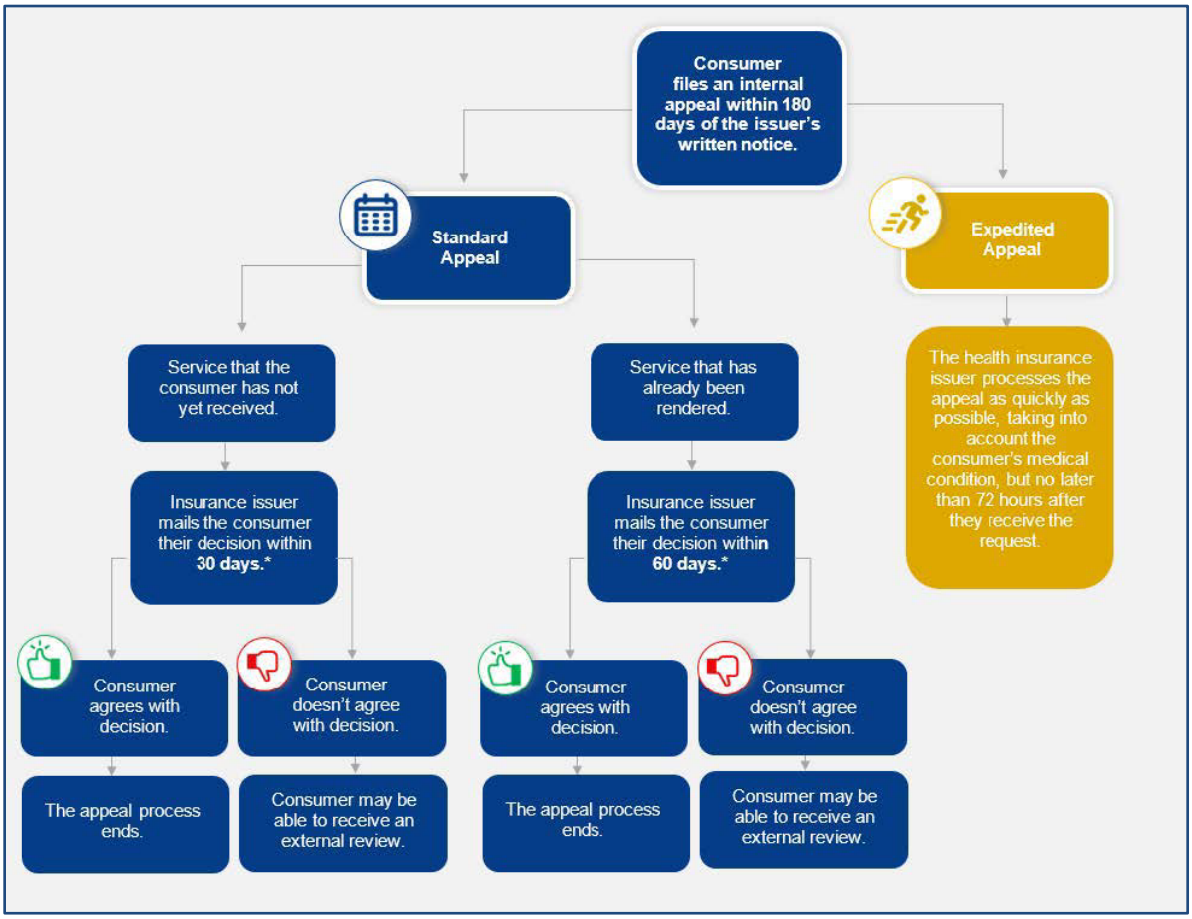
Exhibit 4 – Internal Appeals Decision Timeframes

Type of Claim	Internal Appeals Decision Timeframe
Pre-service (prior authorization)	30 calendar days* (May be extended one time by the plan for up to 15 days if necessary, due to matters beyond the control of the plan and notifies the claimant)
Post-service (reimbursement)	60 calendar days* (May be extended one time by the plan for up to 15 days if necessary, due to matters beyond the control of the plan and notifies the claimant)
Urgent Care	As soon as possible, taking into account the medical exigencies, but not later than 72 hours

*The plan must notify the claimant of an extension prior to the expiration of the initial period.

Exhibit 5 summarizes the internal appeals process.

Exhibit 5 – Internal Appeals Process



* May be extended one time by the plan for up to 15 days, if necessary due to matters beyond the control of the plan and notifies the claimant.

Special Appeals Situations

There are special situations that issuers must consider when reviewing an appeal.

Urgent care

An urgent care situation occurs when:

- The standard appeal timeframe could seriously jeopardize a consumer's life, health, or ability to regain maximum function; or
- In the opinion of a physician with knowledge of the consumer's medical condition, the standard appeal timeframe would subject a consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

In these urgent situations, a consumer may file verbally, and the plan or issuer's notice of an appeal decision may be delivered verbally. Individuals in urgent care situations may initiate an internal appeal and external review simultaneously, even if the consumer hasn't completed all of the plan or issuer's internal appeals processes.

A final decision about the urgent appeal must come as quickly as the consumer's medical condition requires and no later than 72 hours after the request is received. This final decision can be delivered verbally but must be followed by a written notice within 48 hours.

Deemed Exhaustion

In the following cases, an internal appeal is deemed exhausted, allowing a consumer to move to an external review without completing the internal appeals process:

- The plan or issuer waives an internal appeal.
- Urgent care situations (expedited external review may be initiated at the same time as expedited internal appeal).
- Failure to comply with all requirements of the internal appeals process except in cases where the violation was:
    - De minimis (i.e., small scale or of insufficient importance);
    - Non-prejudicial;
    - Attributable to good cause or matters beyond the plan's or issuer's control;
    - In the context of an ongoing good-faith exchange of information; and
    - Not reflective of a pattern or practice of non-compliance.

External Review Process Overview

If a consumer disagrees with a plan or issuer's decision after an internal appeal, they can request an external review. Consumers in all states must have an external review process made available to them that meets the federal consumer protection standards, which are performed at either the state or federal level.

- **State review:** States may have an external review process that meets or goes beyond the minimum federal consumer protection standards. If so, plans and issuers in that state will follow the state's external review process. For self-funded group health plans subject to a state external review process which meets the minimum standards of the National Association of Insurance Commissioners (NAIC) Uniform Model Act, the plan must comply with the applicable state external review process and is not required to comply with the federal external review process.

- Plan or issuer must pay the cost of an independent review organization (IRO) conducting the external review.

- State laws that expressly allowed a filing fee as of November 18, 2015, may continue to allow nominal filing fees.

    - To be considered nominal, a filing fee must not exceed $25, it must be refunded to the claimant if the adverse benefit determination (or final internal adverse benefit determination) is reversed through external review, it must be waived if payment of the fee would impose an undue financial hardship, and the annual limit on filing fees for any claimant within a single plan year must not exceed $75.

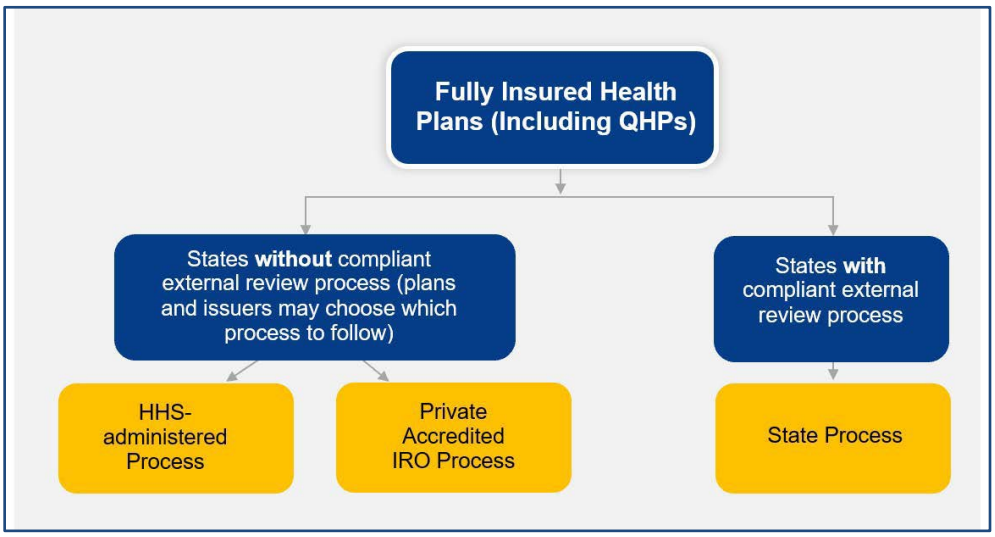
- **Federal review:** If a state does not have an external review process that meets the minimum federal consumer protection standards, the plans and issuers in the state must participate in the Federal external review process (FERP) by electing to either contract with at least three IROs (private accredited IRO process) or utilize the HHS-administered FERP.

- If a plan or issuer is using the HHS-administered federal external review process, there's no charge to file an external review request.

- If the plan or issuer opts to use the private accredited IRO process, the plan or issuer must assign an IRO that is accredited by Utilization Review Accreditation Commission (URAC) or by similar nationally-recognized accrediting organization to conduct the external review on a rotational basis in a non-biased manner.

Exhibit 6 illustrates the state and federal external review process.

Exhibit 6 – State and Federal External Review Process



Steps for External Review Process

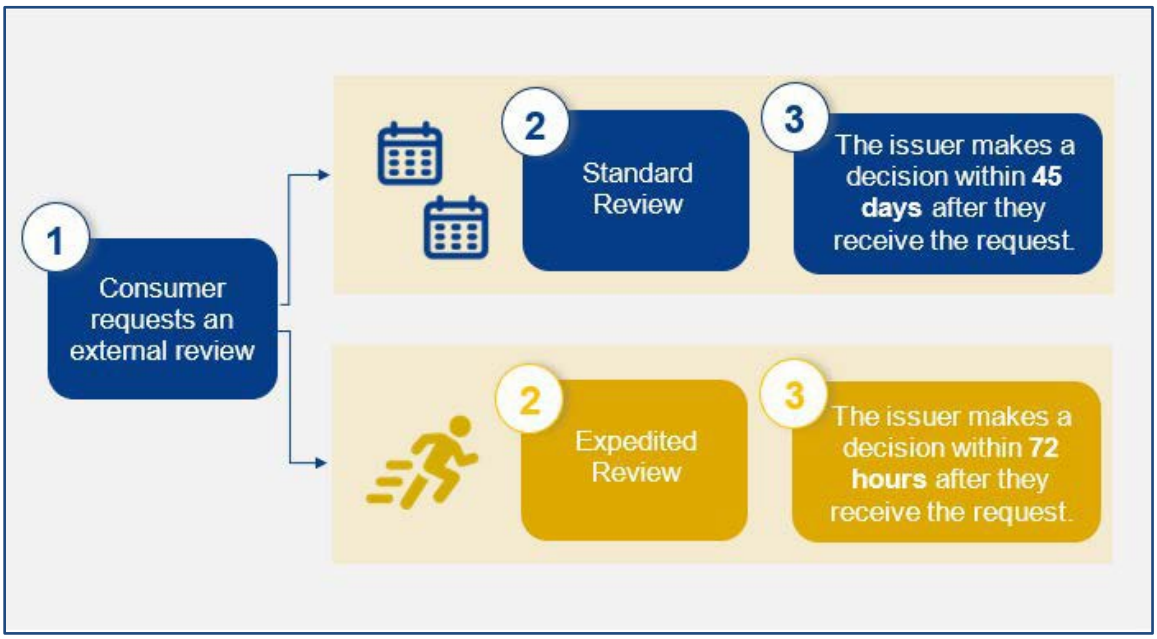
Instructions for requesting an external review are found in health plan documents. There are two steps in the external review process:

1. The consumer files a written request for an external review after they receive a notice or final determination from their plan or issuer that their claim has been denied. A consumer may appoint an authorized representative (like their doctor or another medical professional) who knows about their medical condition to file an external review on their behalf. If the consumer is using the HHS-administered process, they can access an authorized representative form.
2. The IRO issues a final decision. An IRO either upholds the plan or issuer's decision or decides in the consumer's favor. The plan or issuer is required by law to accept the IRO's decision.

Standard external reviews are decided as soon as possible, but no later than 45 days after the request was received. Expedited external reviews are decided as soon as possible, but no later than 72 hours depending on the medical urgency of the case, after the request was received.

Exhibit 7 summarizes the external review process.

Exhibit 7 – External Review Process



State External Review

Scope of Claims Eligible for State External Review. The scope of claims meeting minimum state review standards applies to ABDs based on:

- Medical necessity
- Appropriateness
- Health care setting
- Level of care
- Effectiveness of a covered benefit
- No Surprises Act (NSA) compliance matters,[iii] including:
- Patient cost sharing for emergency services.
- Patient cost sharing related to care provided by nonparticipating providers at participating facilities.
- Whether patients are in a condition to receive notice and provide informed consent to waive NSA protections.
- Whether a claim for care received is coded correctly and accurately reflects the treatments received and the associated NSA protections related to patient cost sharing.

Federal External Review Process

Scope of Claims Eligible for External Review under the Federal External Review Process

The scope of claims eligible for external review under the federal external review process (both HHS-administered and private accredited IRO) includes ABDs (or final internal ABDs) involving:

- Medical judgment, including, but not limited to:
  - Determinations that involve medical necessity
  - Appropriateness
  - Health care setting
  - Level of care
  - Effectiveness of a covered benefit
  - Experimental and investigational treatments
  - Rescission of coverage, if improperly applied; and[iv]
  - NSA compliance matters, including:
  - Patient cost sharing for emergency services
  - Patient cost sharing for care provided to patients by nonparticipating providers at participating facilities
  - Whether patients are in a condition to receive notice and provide informed consent to waive NSA protections
  - Whether a claim for care received is coded correctly and accurately reflects the treatments received and the associated NSA protections related to patient cost sharing and surprise billing

Federal External Review Process Requirements

The federal external review process requirements include minimum consumer protections in the NAIC Uniform Health Carrier External Review Model Act. This Act provides uniform standards for the establishment and maintenance of external review procedures, as described earlier. The federal external review process does not impose any costs, including filing fees, on the claimant requesting the external review.

HHS-administered External Review Process

Plans and issuers that elect to use the HHS-administered federal external review process and their enrollees will work with a designated federal contractor which, in consultation with and on behalf of HHS, performs the administrative functions of the external review. This contractor is MAXIMUS Federal Services, Inc. (MAXIMUS).

Private Accredited IRO Federal External Review Process

If a plan or issuer elects to use the private accredited IRO federal external review process, the plan or issuer must contract with at least three IROs and rotate external review assignments among them. The plan or issuer may use an alternative process for IRO assignment. However, the plan or issuer is expected to document how any alternative process constitutes an impartial assignment method and how it ensures that the process is independent and unbiased. The plan or issuer is not permitted to provide financial incentives to IROs based on the likelihood that the IRO will support the denial of benefits.

Additional Information about External Reviews Related to NSA Compliance Matters

If a state external review process cannot accommodate external reviews of NSA compliance matters, HHS is offering states the opportunity to refer external review requests that involve NSA compliance matters to the federal HHS-administered external review process. States that HHS has previously determined meet the minimum standards for state external review may direct plans and issuers to use the federal HHS-administered process for external review of NSA compliance matters and will still be considered to have an applicable state external review process.

Alternatively, plans and issuers subject to an applicable state external review process that cannot accommodate external review of NSA compliance matters may choose to use the accredited IRO-contracting federal external review process for NSA compliance matters only. However, plans and issuers must meet all requirements under those rules, including the requirement to make any necessary changes to existing contracts with IROs to accommodate external reviews of NSA compliance matters, as well as updating plan documents.

Additional Resources

- Coverage Appeals Regulations
  - Regulations and guidance are available on the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight (CCIIO) website: CMS.gov/cciio/resources/regulations-andguidance#External_Appeals
- Resources at CMS.gov:
  - Affordable Care Act: Working with States to Protect Consumers: CMS.gov/CCIIO/Resources/Files/external_appeals
  - HHS-Administered Federal External Review Process for Health Insurance Coverage: CMS.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-andInformation/csg-ext-appeals-facts
  - Internal Claims and Appeals and the External Review Process Overview webinar: CMS.gov/marketplace/technical-assistance-resources/internal-claims-and-appeals.pdf
  - Marketplace Appeals job aid: CMS.gov/files/document/marketplace-appeals-job-aid.pdf
  - HHS-Administered Federal External Review Process (MAXIMUS): Maximusferp.my.site.com/FERP/s/#/home
  - HHS Federal External Review Process Appointment of Representative Form: Maximusferp.my.site.com/FERP/resource/1729867025000/FERP_Representative_Form
- Resources at HealthCare.gov:
  - How to appeal an insurance company decision: HealthCare.gov/appeal-insurance-company-decision/internal-appeals/

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[i] An individual health insurance policy purchased on or before March 23, 2010. These plans weren't sold through the Marketplace, but by insurance companies, agents, or brokers. They may not include some rights and protections provided under the Affordable Care Act.
[ii] Requirements Related to Surprise Billing; Part II Interim final rules with request for comment, 86 FR 55980 (Oct. 7, 2021), Federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii.
[iii] NSA compliance matters were added to the scope of state external reviews beginning January 1, 2022.
[iv] 45 CFR §147.128