Ending Marketplace Coverage & Coverage Appeals

Centers for Medicare & Medicaid Services (CMS)
Center for Consumer Information & Insurance Oversight (CCIIO)

March 28, 2024

Disclaimer

The information provided in this presentation is intended only as a general, informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This presentation summarizes current policy and operations as of the date it was presented. Links to certain source documents have been provided for your reference. We encourage audience members to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information about the requirements that apply to them. The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

This document generally is not intended for use in the State-based Marketplaces (SBMs) that do not use HealthCare.gov for eligibility and enrollment. Please review the guidance on our Agent and Broker Resources webpage (http://go.cms.gov/CCIIOAB) and Marketplace.CMS.gov to learn more.

Unless indicated otherwise, the general references to "Marketplace" in the presentation only include Federally-facilitated Marketplaces (FFMs) and State-based Marketplaces on the Federal Platform (SBM-FPs).

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Agenda

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Opening Remarks

Reminder: Documenting Consumer Consent Requirement

Consent Documentation Requirements

- Agents, brokers, and web-brokers are required to document the receipt of consent from the consumer or their authorized representative.
  - The consumer or their authorized representative must take an action to produce the documentation;
  - The documentation must contain, at a minimum, the following information:
    - A description of the scope, purpose, and duration of the consent provided by the consumer or their authorized representative;
    - The date the consent was given;
    - The name of the consumer or their authorized representative;
    - The name of the agent, broker, web-broker, or agency being granted consent;
    - A process through which the consumer or their authorized representative may rescind the consent.
  - The agent, broker, or web-broker must maintain the documentation for **a minimum of 10 years.**

For more information on these requirements, view these FAQs here: https://www.cms.gov/files/document/2024-pn-ab-faq-9823.pdf **and webinar slides here:** https://www.cms.gov/files/document/marketplace-compliance-2024-payment-notice-updates-webinar-slides.pdf**.**

Reminder: Documenting Application Review Requirement

Review Documentation Requirements

- Agents, brokers, and web-brokers are required to document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or their authorized representative prior to application submission.
  - The consumer or their authorized representative must take an action to produce the documentation;
  - The documentation must contain, at a minimum, the following information:
    - The date the information was reviewed;
    - The name of the consumer or their authorized representative;
    - An explanation of the attestations at the end of the eligibility application; and
    - The name of the assisting agent, broker, or web-broker.
  - The agent, broker, or web-broker must maintain the documentation for **a minimum of 10 years.**

For more information on these requirements, view these FAQs here: https://www.cms.gov/files/document/2024-pn-ab-faq-9823.pdf **and webinar slides here:** https://www.cms.gov/files/document/marketplace-compliance-2024-payment-notice-updates-webinar-slides.pdf**.**

Reminder: Changing NPNs on Marketplace Applications

Review Requirements for Changing NPNs on a Consumer's Application

- Documented consent must be obtained from the consumer when an NPN on a Marketplace application is being changed from one agent or broker to another.
- Consent must be documented prior to assisting the consumer with applying for or enrolling in coverage.
- If a consumer has granted agency-wide consent, the agency will not be required to obtain new consent when the NPN on the consumer's application changes, provided:
  - The consumer's consent has not expired or been rescinded; and
  - The new NPN belongs to an agent or broker of the agency to whom the consumer granted consent.

Agents, brokers, and web-brokers may never make any changes to a consumer's eligibility application without obtaining and documenting that the consumer has consented to this change and reviewed and confirmed this new eligibility application information.

For more information on these requirements, view these FAQs here: https://www.agentbrokerfaq.cms.gov/s/article/How-do-the-consent-requirements-adopted-in-the-2024-Payment-Notice-relate-to-NPNs-being-changed-on-Marketplace-applications **and webinar slides here:** https://www.cms.gov/files/document/marketplace-compliance-2024-payment-notice-updates-webinar-slides.pdf.

Overview of Ending Marketplace Coverage

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Overview of Ending Marketplace Coverage

- When and how consumers end a Marketplace plan depends on:
  - **The reason they are ending coverage**
  - **Which consumers on the plan are cancelling coverage** (i.e., for everyone on the Marketplace application or just for some household members)

Overview of Ending Marketplace Coverage

» Reasons for ending coverage may include:

Job-based coverage	Obtaining employer-sponsored health insurance.
Other source of coverage	Obtaining coverage through another source.
Medicaid/CHIP eligibility	May be eligible for Medicaid or the Children's Health Insurance Program (CHIP).
Medicare	Becoming eligible for Medicare.

Overview of Ending Marketplace Coverage (continued)

» Reasons for ending coverage may include:

Change in residence	Moving outside the plan's coverage area (a different state).
Death of applicant	Ending coverage because someone on their application died.
Grandfathered plan changed or cancelled	Are informed their “grandfathered” health plan is being changed or cancelled.

Overview of Ending Marketplace Coverage (continued)

Consumers should not end their Marketplace plan until they know when their new coverage starts.

Once consumers end their Marketplace coverage, they cannot re-enroll in a Marketplace plan until the next Open Enrollment Period (OEP).*

** Unless the consumer qualifies for a Special Enrollment Period (SEP).*

Overview of Ending Marketplace Coverage (continued)

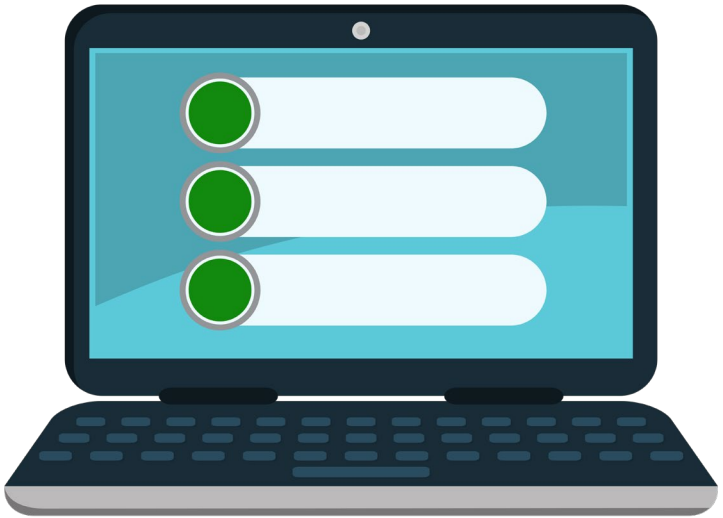
- Marketplace coverage does not end automatically if a consumer is found eligible for Medicare, Medicaid or CHIP.
  - Agents and brokers should explain to consumers that if they do not cancel their enrollment with financial assistance through the Marketplace, **they may have to pay back the advance payments of the premium tax credit (APTC)** that they received through the Marketplace for the months they were eligible for Medicare, Medicaid or CHIP coverage.

Overview of Ending Marketplace Coverage (continued)

- **For example:** If the consumer updates their household income at the same time as ending coverage for one or more people (but not everyone), they may qualify for an SEP making their effective date the first of the next month, **which may not align with when they want coverage to end**.
- These "some-but-not-all" terminations should be **requested at the Marketplace Call Center** so that a Marketplace representative can open a Health Insurance Casework System (HICS) case to establish the desired termination date, if necessary.

Overview of Ending Marketplace Coverage (continued)

- Consumers can use the **How to cancel your Marketplace plan tool** for step-by-step instructions on ending Marketplace coverage through HealthCare.gov.
- In some cases, the system will not assign the termination date immediately if household members staying on the plan qualify for an SEP.



See the tool at HealthCare.gov here: https://www.healthcare.gov/how-to-cancel-a-marketplace-plan/

When and How to End Marketplace Coverage

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When and How to End Marketplace Coverage

For Some People on the Plan

When: Consumers may request the following end dates for their Marketplace coverage:

- Same day; or
- Future date.

How: Only by calling the Marketplace Call Center to:

- End coverage for only some people on the plan;
- End the subscriber's Marketplace coverage (requires designating a new subscriber); and
- Ensure that those remaining on their Marketplace plan don't lose their coverage.

When and How to End Marketplace Coverage (continued)

For Everyone on the Plan

When: Consumers may request the following end dates for their Marketplace coverage:

- Same day; or
- Future date.

How: Consumers may:

- Update their existing application on HealthCare.gov or through an approved Enhanced Direct Enrollment (EDE) partner's website.
- Contact the Marketplace Call Center by phone at 1-800-318-2596 (TTY: 1-855-889-4325).

End Coverage for a Deceased Person by an Individual NOT on the Enrollee's Application

- If an individual needs to end coverage for an enrollee who has died and the individual is **not** the household contact or a member of the household on the deceased's Marketplace application, the individual can report the death of the deceased enrollee if:
  - they are **at least 18 years old**; and
  - they **submit documentation** that verifies the death, which may include:

Death certificate

Obituary

Court document providing proof of death

Proof that somebody has been named executor of the estate

End Coverage for a Deceased Person by an Individual NOT on the Enrollee's Application (continued)

- The documents should include the following information about the deceased:
  - Full name
  - Date of birth (DOB)
  - Application ID (if known)
  - Social Security number (SSN) (if known)
  - Contact information for the person submitting the documentation (name, address, and phone number)

- Mail copies of all documents to:

Health Insurance Marketplace
ATTN: Coverage Removal
Dept. of Health and Human Services
465 Industrial Blvd. London, KY 40750-0001

Ending Stand-Alone Dental Plan Coverage

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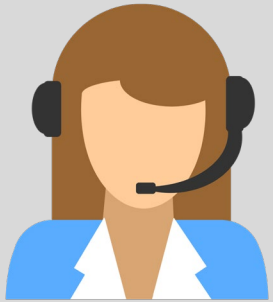
Ending Stand-Alone Dental Plan Coverage

» If a consumer voluntarily ends their dental coverage or is terminated for not making premium payments, they may not be eligible to enroll in dental coverage until the next OEP.



Consumers may contact their issuer directly if they would like to end their stand-alone dental plan.

Marketplace to Medicare Transitions

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Transitioning from Marketplace Coverage to Medicare

Consumers should not end their Marketplace plan until they know for sure when their Medicare coverage starts. Once they end Marketplace coverage, they can't re-enroll until the next annual OEP (unless they qualify for an SEP).

Consumers should end Marketplace coverage with PTC or other cost savings for anyone in the household who is gaining Medicare.

Consumers who do not end their Marketplace coverage as soon as their Medicare coverage begins **may need to pay back any APTC received after the consumer started Medicare** when they file and reconcile their taxes.

In some cases, consumers will need to end their Marketplace coverage by calling the Marketplace Call Center. In other cases, consumers can end their coverage on HealthCare.gov or through an approved EDE partner's website.

When and How to End Marketplace Coverage: Marketplace to Medicare

For Some People on the Plan

When: The consumer who is transitioning to Medicare should report the life change **on the day their Medicare starts.**

How: Only by calling the Marketplace Call Center to:

- End coverage for only some people on the plan;
- End the subscriber's Marketplace coverage (requires designating a new subscriber); and
- Ensure that those remaining on their Marketplace plan don't lose their coverage.

When and How to End Marketplace Coverage: Marketplace to Medicare

For Everyone on the Plan

When: Consumers may request the following end dates for their Marketplace coverage:

- Same day; or
- Future date.

How: Consumers may:

- Update their existing application on HealthCare.gov or through an approved EDE partner's website; or
- Contact the Marketplace Call Center by phone at 1-800-318-2596 (TTY: 1-855-889-4325).

Best Practices for Transitioning Consumers from Marketplace to Medicare Coverage

- When the primary applicant is going on Medicare, but their spouse will remain on the plan, **the consumer should report the life change the first day their Medicare starts**.

- So those not aging into Medicare remain covered, CMS suggests **designating the youngest adult or caretaker as the household contact**, allowing consumers to easily update their application online without calling the Marketplace Call Center.

For more instructions on how to time ending Marketplace coverage and signing up for Medicare, visit: https://www.healthcare.gov/medicare/changing-from-marketplace-to-medicare/.

Marketplace to Medicaid Transitions

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Transitioning Between Medicaid and the Marketplace

Consumers should immediately end Marketplace coverage with PTC or other cost savings for anyone in the household who is determined eligible for or already enrolled in Medicaid or CHIP that counts as qualifying health coverage.

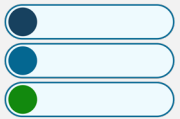
Consumers should not end their Marketplace plan before they get a final decision of their Medicaid or CHIP eligibility. If they apply for Medicaid or CHIP and are found to be ineligible, they can't re-enroll in the Marketplace plan unless they qualify for an SEP.

- Otherwise, consumers must wait for the next OEP and may have a gap in coverage.

Consumers who lose Medicaid or CHIP coverage **between March 31, 2023**, and **July 31, 2024**, will be eligible for a 60-day SEP, referred to as the "Unwinding SEP".

Transitioning Between Medicaid and the Marketplace (continued)

Consumers who lose Medicaid or CHIP coverage during this timeframe can submit or update a Marketplace application anytime on HealthCare.gov and **will have 60 days after submitting their application to pick a plan**. Consumers will receive the Unwinding SEP automatically based on their answers to application questions and can apply for Marketplace coverage any time after receiving their eligibility determination from their State Medicaid Agency.



Examples of coverage transition scenarios regarding transitioning from Medicaid to the Marketplace can be found here: https://www.cms.gov/files/document/ab-summit-2023-navigating-medical-unwinding-period.pdf

Transitioning Between Medicaid and the Marketplace (continued)

- For consumers who attest to a loss of Medicaid or CHIP coverage in the past, Marketplace coverage will start the **first of the month following plan selection**.
- For consumers who attest to a future loss of Medicaid or CHIP coverage, Marketplace coverage will **start the first day of the month after their last day of Medicaid coverage**.
- See the table below for examples of coverage start dates.

Medicaid/CHIP Coverage End Date	Date of Marketplace Plan Selection	Marketplace Plan Effective Date
July 31, 2024	June 25, 2024 (**before** Medicaid coverage ends)	August 1, 2024
July 31, 2024	October 5, 2024 (**after** Medicaid coverage ends)	November 1, 2024

Transitioning Between Medicaid and the Marketplace (continued)

- **Reminder:** It is critical for agents and brokers to remind consumers that they must answer these questions accurately to help ensure consumers are evaluated for the appropriate coverage and SEPs, as applicable.
- Agents or brokers may not attest that the consumer has been denied Medicaid or CHIP coverage in their enrollment application for Marketplace coverage unless the consumer has actually been denied by the state Medicaid/CHIP agency.

If the consumer has not been notified of denial of coverage by the State Medicaid Agency, agents and brokers should not attest that the consumer has been denied Medicaid or CHIP coverage.

SEP Transitions

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SEP Actions for Consumers

- Consumers who experience a qualifying life event may be required to report it by completing a change in circumstance (CiC) application within 30 days of the change.
- A consumer's SEP window during which they may select a plan is generally 60 days from the qualifying life event.

Consumers who wait until the very end of the SEP window **run the risk of missing the deadline** to select a qualified health plan (QHP).

Some SEPs are only available to consumers who had prior qualifying health coverage for **one or more days in the 60 days preceding** their SEP qualifying event.

SEP Actions for Consumers for the Unwinding SEP

- To ensure continuity of coverage, consumers should complete or update a Marketplace application as soon as they receive a determination of ineligibility from their State Medicaid Agency.
- To receive the **Unwinding SEP,** consumers must:

1. Submit a new application or update an existing application between **March 31, 2023**, and **July 31, 2024**, and answer "Yes" to the application question asking if their Medicaid or CHIP coverage recently ended or will soon end; and

2. Attest to a Medicaid or CHIP coverage loss between **March 31, 2023,** and **July 31, 2024.** Consumers will then have 60 days to select a new plan for Marketplace coverage.

Appealing Marketplace Eligibility Determinations

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Appealing Marketplace Eligibility Determinations

- If a consumer believes their Marketplace eligibility results are incorrect, agents and brokers can help consumers file an appeal with the Marketplace Appeals Center.
- You should encourage your clients to consider the following information when planning an appeal:

Only certain eligibility determinations can be appealed.

A legally-appointed authorized representative can file or participate in the consumer's appeal. A new form or letter must be submitted to authorize a new or existing representative for their appeal.

Appealing Marketplace Eligibility Determinations (continued)

If your client files an appeal, they may be able to keep their coverage while the appeal is pending.

The outcome of an appeal could change the eligibility of other members of their household, even if they did not ask for an appeal.

Appealing Marketplace Eligibility Determinations (continued)

- Consumers can **submit an Appeal Request online** on HealthCare.gov, which is the quickest option, or write a letter asking for their appeal.
- This letter should include the consumer's:

Name

Address

Reason for appealing

- If your client is requesting an appeal for someone else, they should also **include that person's name.**

Which Eligibility Determinations Can Be Appealed

» Consumers can appeal the following types of Marketplace eligibility determinations:

Eligibility to buy a Marketplace plan, including a catastrophic plan

Eligibility for APTC or CSRs, including the amount

Eligibility for an SEP to enroll in or change a Marketplace plan outside the annual OEP

Eligibility for Medicaid or CHIP*

Any SBM eligibility appeal decision or its decision denying the consumer's request to vacate the dismissal of their eligibility appeal

Whether the Marketplace made a timely determination about their eligibility after they applied

** This applies only in states where the Marketplace makes the Medicaid or CHIP eligibility determination (Alabama, Alaska, Louisiana, Montana, North Carolina, West Virginia, and Wyoming).*

Determining if a Consumer's Appeal is Valid

» The Marketplace Appeals Center applies several criteria when determining if a consumer's appeal is valid:

1. Your client's appeal must be about an **eligibility determination that is appealable**.
2. Your client (or their authorized representative) must file the appeal request within the following timeframes:

90 days of the contested Marketplace eligibility determination

OR

30 days of an SBM appeal decision

OR

30 days of notice from an SBM declining to reopen the appeal after it was dismissed by the SBM

Determining if a Consumer's Appeal is Valid (continued)

- After your client files an appeal, they will receive a letter from the Marketplace indicating if their appeal has been **accepted** or is invalid.

- If the appeal request is **accepted**, the Marketplace Appeals Center will review the appeal, including information the Marketplace uses to determine their eligibility.
- The Appeals Center may send the consumer a letter **asking for more documentation from your client** during the appeal decision process.
  - This letter contains a unique appeal number that outlines the appeals process and includes instructions for submitting additional information or documentation, if it's needed.
  - Agents and brokers should encourage clients to provide this information as soon as possible, as this may help the Appeals Center resolve their case quickly.

Determining if a Consumer's Appeal is Valid (continued)

Agents and brokers should remind clients to write their appeal number on any documents they submit to the Marketplace Appeals Center.

Determining if a Consumer's Appeal is Valid (continued)

- After your client files an appeal, they will receive a letter from the Marketplace indicating if their appeal has been accepted or is **invalid**.

- If the appeal request is **invalid**, your client will receive a notice explaining:
  - why their request doesn't meet requirements; and
  - how they can resolve the issue to resubmit their appeal.

For more information on the resolution process, visit: https://www.cms.gov/marketplace/technical-assistance-resources/training-materials/marketplace-eligibility-appeals.pdf.

Marketplace Coverage & Coverage Appeals Resources

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Helpful Resources

HealthCare.gov Resources

How to Cancel a Marketplace Plan on HealthCare.gov	https://www.healthcare.gov/how-to-cancel-a-marketplace-plan/
Changing from the Marketplace to Medicare	https://www.healthcare.gov/medicare/changing-from-marketplace-to-medicare/
Filing an Appeal Request Online	https://www.healthcare.gov/marketplace-appeals/appeal-forms/

Helpful Resources (continued)

CMS.gov Resources

Agent and Broker Toolkit: Transitions in Coverage	https://www.cms.gov/files/document/agent-and-broker-toolkit-transitions-coverage.pdf
Navigating the Medicaid Unwinding Period Webinar Slides	https://www.cms.gov/files/document/ab-summit-2023-navigating-medical-unwinding-period.pdf
"Cancelling or Terminating Consumer Marketplace Coverage" Tip Sheet	https://www.cms.gov/files/document/cancelling-or-terminating-consumer-marketplace-coverage.pdf
"From Marketplace to Medicare" Webinar Slides	https://marketplace.cms.gov/technical-assistance-resources/medicare-and-marketplace.pdf
What You Need to Know About Medicaid and the Unwinding Period Video	https://www.youtube.com/watch?v=9Ip6v_rvmNM&list=PLaV7m2-zFKpgUK9AqdbnOdW69-WwodvRj&index=26
Unwinding Marketplace FAQ Companion Resource	https://www.cms.gov/files/document/faqs-companion-resource.pdf

Helpful Resources (continued)

Agents and Brokers Resources

Cancelling a Marketplace Plan FAQ	https://www.agentbrokerfaq.cms.gov/s/article/How-can-a-consumer-cancel-or-terminate-a-Marketplace-plan
Marketplace Appeals FAQs	https://www.agentbrokerfaq.cms.gov/s/global-search/appeals
Determining if an Appeal if Valid FAQ	https://www.agentbrokerfaq.cms.gov/s/article/How-does-the-Marketplace-Appeals-Center-determine-if-my-client-s-appeal-is-valid
Appointing an Authorized Representative FAQ	https://www.agentbrokerfaq.cms.gov/s/article/How-can-a-consumer-appoint-an-authorized-representative-to-handle-their-appeal

Agents and brokers are valued partners to all of us at CMS for the vital role you play in enrolling consumers in qualified health coverage.

We thank you for the trusted advice, support, and assistance you provide throughout the year and wish you continued success!