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From: Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services

Title: Affordable Exchanges Guidance

Subject: Bulletins on Enrollment and Termination Policies and Processes for FFM and SPM Issuers

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CMS has finalized a series of processes and policies regarding enrollment and termination for issuers participating in Marketplaces using the CMS system, including Federally-facilitated Marketplaces (FFM) and State Partnership Marketplaces. This set of guidance covers a variety of topics related to consumers or issuers being able to make changes to information or plan selections based on changes in life circumstances or as the result of being granted a special enrollment period.

New functionality in the FFM will allow consumers to make certain changes to their application. The attached guidance represents a series of bulletins and FAQs related to consumer changes where new functionality is available. Interim processes are outlined for situations where functionality is not yet available, such as special enrollment periods (SEPs).

This guidance works in conjunction with previously issued guidance including the December 12, 2013 Interim Final Rule, the FFM Enrollment Operational Policy and Guidance issued in draft on October 3, 2013[1], and all previously released bulletins except where otherwise indicated. The following bulletins are attached:

- **Bulletin #2:** Functionality for Consumer-Initiated Application and Enrollment Changes
- **Bulletin #3:** Special Enrollment Periods: Effective Dates and Processes
- **Bulletin #4:** Enrollee-Initiated Terminations
- **Bulletin #5:** Flexibility During the Initial Open Enrollment Period to Change Plans Offered by the Same Issuer at the Same Metal Level
- **Bulletin #6:** Clarifications of the Instructions Presented in the December 12, 2013, Interim Final Rule and Bulletin #001

[1] Available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR_OperationsPolicyandGuidance_5CR_100313.pdf

Bulletin #2: Functionality for Consumer-Initiated Application and Enrollment Changes

The guidance below provides the process to allow consumers to make changes to their application through healthcare.gov. This replaces previously issued guidance in which CMS allowed enrollees to add a dependent as a result of a birth, adoption, or placement for adoption or foster care through their qualified health plan (QHP). New functionality on healthcare.gov allows consumers to report changes directly through the Federally-facilitated Marketplace (FFM). In some cases, consumers may receive an SEP eligibility determination as a result of these changes. Current functionality does not allow for the granting of all SEPs; for example, the granting of SEPs that arise due to changes in income that result in a person becoming newly eligible or ineligible for Advance Payments of the Premium Tax Credit or for cost-sharing reductions. Issuers will be notified when this functionality is available.

Process:

1. The consumer logs in to their account and presses the "Report a Life Change" button (this button is only enabled for consumers who have already submitted an application).
2. The consumer will land on a page with information about the types of changes that must be reported to the Marketplace or both the Marketplace and the issuer[2]. Changes which do not impact eligibility, such as an address change within the same zip code and county, must be reported to both the issuer and the Marketplace, as an 834 will not be generated.
3. If the consumer has changes to report that may affect eligibility, a new copy of their application is created, pre-populating some information and attestations from their earlier application.
4. The consumer completes the new application and answers questions which determine whether the applicants for whom new information is being provided are eligible for QHP enrollment through the FFM, and if so, whether the new information triggers a Special Enrollment Period (SEP).
5. If the consumer is eligible for an SEP, the consumer's eligibility determination notice will contain SEP eligibility language.
6. If any applicants for whom new information is being provided are eligible to enroll in a QHP through a Marketplace (i.e., they are qualified individuals), the qualified individual will proceed to the enrollment to-do list page.
    a. If the applicant for whom new information is being provided is a qualified individual and his/her addition to coverage is based on an event that triggers an SEP, the qualified individual will have the ability to compare and select from all QHPs available to the applicants in the service area.
    b. If the new information being provided does trigger an SEP, the qualified individual will be limited to updating his or her enrollment information in the QHP in which he or she is currently enrolled.
7. The qualified individual will select a new plan (or the existing plan, depending on the situation) and set the amount of APTC the tax household will use.
8. Once the qualified individual selects a plan, the system will generate an 834 termination transaction to the issuer with whom the individual was initially enrolled, and an 834 enrollment transactions will be sent to the gaining issuer (in cases where the qualified

[2] See appendix A

individual updates his or her existing enrollment, the enrollment transaction will go to the same issuer and should be treated as a modification, rather than a new enrollment).

Effective Dates:

The qualified individual's effective date depends on whether the individual is eligible for an SEP, and if so, the type of SEP, and the time of month the plan is selected, in accordance with the below chart:

Type of SEP	**Termination Date of Existing Enrollment, if Currently Enrolled**	**Plan Selection Date**	**Effective Date**
Not eligible for an SEP or eligible for the following SEPs: 1. Move to a new exchange service area 2. Release from incarceration 3. Becoming lawfully present 4. Gain status as an Indian	Day before effective date	Between the 1st and 15th day of the month (Between 1/1/14 and 3/15/14)	First day of the following month
		Between the 16th and last day of the month (Between 1/16/13 and 03/31/14)	First day of the second following month
Loss of MEC and gaining a dependent through Marriage SEP	Day before effective date	Any day of the month	First day of the following month
Future loss of MEC (loss up to 60 days in the future)	Day before effective date	Any day of the month	First day of the month following the date of the loss of MEC
Birth, adoption, or placement for adoption or foster care SEP	Day before effective date	Any day of the month	Day the child was born, adopted, or placed for adoption or foster care

Future functionality:

Additional functionality will be released in the near future which will allow consumers to be determined eligible for an SEP based on new eligibility or ineligibility for advance payments of the premium tax credit (APTC), or changes in cost-sharing reductions (CSR). The current release will allow consumers to report income changes, and will recalculate APTC and CSR, but will not provide an SEP for these changes. CMS also plans to add functionality for qualified individuals to conduct a search of available plans by Plan ID, which will help qualified individuals who are eligible for an SEP and want to enroll in the same plan.

Frequently Asked Questions:

Q1: Does this process apply to the previously issued guidance on exceptional circumstance, misrepresentation, enrollment error, or plan data error SEPs?

A1: This guidance does not replace any previously issued guidance regarding exceptional circumstances, misrepresentation, enrollment errors, or plan data error SEPs. CMS will continue to issue exceptional circumstance, misrepresentation, and enrollment error SEPs using the already defined process.

Q2: Does this process change previously issued guidance which allowed qualified individuals to add dependents due to birth, adoption, or placement for adoption or foster care?

A2: Yes, qualified individuals should now report all changes directly to the Marketplace. This includes situations where an individual is seeking to add a dependent due to birth, adoption, or placement for adoption or foster care.

Q3: What enrollment transaction will the issuer receive?

A3: The issuer will receive an 834 termination transaction from the Marketplace followed by an 834 initial enrollment transaction. This is true for qualified individuals who are re-enrolling in the same plan either due to making a change that did not allow for a SEP and for qualified individuals who are eligible for a SEP but choosing the same plan. The issuer will be responsible for ensuring maximum out-of-pocket expenses and deductibles do not reset for the enrollment group.

Q4: Can a consumer report a change in circumstance through the agent/broker or direct enrollment process?

A4: At this time consumers should report changes directly to healthcare.gov.

Q5: Can a consumer use this functionality to remove individuals who are enrolled in separate medical and dental plans from only the medical plan or the dental plan?

A5: At this time the functionality does not support the option to remove a specific individual from a dental plan and keep them on a medical plan or vice-versa. When an applicant is removed from an application, or loses eligibility for enrollment in a QHP, all coverage for that person is terminated. Remaining applicants are enrolled in the prior policies, unless the removal of a member invalidates the prior policy, in which case remaining applicants are granted a SEP.

Appendix A: Reportable Changes

Type of Change	Where to Report
1. Increase or decrease in estimated annual income for 2014 or change to current month's income	Marketplace
2. Add or remove application member	Marketplace
3. Relocation to a new zip code or county	Marketplace
4. Gain or loss of health coverage	Marketplace
5. Anyone on the prior application has become pregnant	Marketplace
6. Change in tax filing status (will or won't file, joint or separate filer) or change in tax dependents that will be claimed	Marketplace
7. Became incarcerated or is released from incarceration	Marketplace
8. Change in immigration status or citizenship	Marketplace
9. Change in status as member of federally recognized Tribe	Marketplace
10. Became disabled or in need of long term care (or is no longer in need of care)	Marketplace
11. Changes to employer coverage	Marketplace
12. Correct/update the relationships between family members	Marketplace
13. Name changes	Issuer & Marketplace
14. Email changes	Issuer & Marketplace
15. Phone number changes	Issuer & Marketplace
16. Address changes within the same zip code and county	Issuer & Marketplace
17. Contact method preference changes	Issuer & Marketplace
18. Authorized representative changes	Issuer & Marketplace

Bulletin #3: Special Enrollment Periods: Effective Dates and Processes

Several categories of special enrollment periods (SEPs) exist that allow a consumer to enroll in a Qualified Health Plan (QHP) with accelerated effective dates or to change their QHP selection. These SEP types are handled through a special process outlined below and are not initiated through the Qualified Individual Initiated Application and Enrollment Changes Functionality recently added to the Federally-facilitated Marketplace. They include:

1. SEPs that have accelerated coverage effective dates with no prior QHP enrollment:
    a. Enrollment error SEP
    b. Exceptional circumstance SEP
    c. Misrepresentation SEP
2. SEPs that permit a consumer to change from a prior QHP enrollment:
    a. Marketplace benefit display errors
    b. Issuer benefit display errors
    c. Misrepresentation SEP

How are SEPs with accelerated effective dates processed?

Consumers seeking an SEP when they have not yet completed an initial enrollment need to call the Marketplace call center. Call center representatives will help the consumer select a plan and forward cases that need additional review to CMS caseworkers. The consumer's situation will be evaluated by a caseworker, if appropriate, to determine whether to grant an SEP. If the SEP is granted, a record will be assigned to issuers through the Health Insurance Casework System (HICS) directing them to move the coverage effective date, if applicable. Effective dates will generally be for the first of the next available month. Therefore, enrollments in the first half of a month will not require a change in effective date; enrollments that occur after the fifteenth are eligible for earlier coverage effective dates, as shown in the table below[3].

Plan Selection Date	*Normal Effective Date*	*Accelerated SEP Effective Dates for 2014*
January 1 – January 15	February 1	January 1
January 16 – January 31	March 1	February 1
February 1 – February 15	March 1	March 1
February 16 – February 28	April 1	March 1
March 1 – March 15	April 1	April 1
March 16 – March 31	May 1	April 1

How are SEPs that allow a consumer to change QHPs processed?

CMS will implement an interim process for allowing someone already enrolled in a QHP to select a new QHP by calling the Marketplace call center. The call center will help the consumer create a new application, including a new eligibility determination, and select a QHP. The issuer of the QHP in which the consumer was previously enrolled will be directed to terminate the

[3] This presumes that the triggering event occurred prior to the most recent plan selection cutoff and provides consumers eligible for the SEP with the coverage effective date they would have had if the triggering event had not occurred.

coverage on the day before the new coverage effective date. Generally, the effective dates will follow the accelerated SEP effective date schedule, with exceptions as determined by CMS.

How will benefit display errors be identified and resolved?

Benefit display errors will be identified after CMS investigates potential display discrepancies raised by issuers or consumers, or noticed by CMS. Marketplace benefit display errors include situations where coding on healthcare.gov displayed benefits incorrectly. Issuer benefit display errors include situations where an issuer notices that they submitted incorrect data for a plan. When a benefit display error is identified, CMS will work with the issuer to ensure that the error is corrected as quickly as possible to ensure that enrollments moving forward are based on accurate information.

In order to resolve the impact of the error on current enrollees when the change either reduces a benefit or increases costs to the consumer, CMS will work with the issuer and state department of insurance to arrive at a solution that has a minimal impact on impacted consumers and ensures, to the extent possible, that they are not negatively affected by a Marketplace or issuer error. The option that is the most beneficial to the consumer and the most straightforward to implement for issuers, consumers, and CMS is for issuers to honor the benefit that was displayed incorrectly for current enrollees. If the issuer honors the benefit as displayed for current enrollees, no further action would be needed.

What if the issuer does not honor the benefit as displayed incorrectly?

CMS is committed to ensuring, to the extent possible, that consumers are not negatively impacted by Marketplace or issuer benefit display errors. Depending on the significance of the benefit display error, there could be several options for mitigating impacts. If a benefit display error would not have a substantial impact on the consumer, an issuer may be able to send out an "errata" notice that informs the consumer of the benefit difference. CMS will work with the issuer to determine whether the benefit display error is minimal enough to fall into this category. We anticipate releasing future guidance on this issue.

If the benefit display error is significant and it is reasonable to expect that it may have impacted a consumer's purchasing decision, then issuers will need to inform the enrollees of the error and present them with other options. With respect to significant Marketplace benefit display errors, CMS will work with the impacted issuers to provide consumers with options to enroll in other QHPs offered by the issuer within the same level of coverage. In these cases, issuers should follow the guidance in bulletin #5 on allowing consumers to switch QHPs within metal tiers. CMS believes that remaining with the issuer will provide a benefit to consumers in that it requires minimal actions on their part and would allow any out-of-pocket costs already incurred to be transferred to their new QHP to count towards the new plan's deductible and the maximum out-of-pocket costs.

What if the consumer does not want to enroll in another QHP offered by the same issuer?

If a consumer is not able to find another QHP offered by the same issuer that meets their needs, then the consumer would be directed to the Marketplace call center to review and select QHPs available to them. Consumers would generally have 60 days to select a new plan. Depending on the type of benefit display error, the consumer may have the option to choose a retroactive

coverage effective date back to the original enrollment or prospective to the first day of the next month. CMS will determine whether a given benefit display error warrants the option for a retroactive coverage date. However, CMS will only determine that retroactive coverage would be appropriate if the consumer selects a new plan within ten business days of receiving notification of the data error. We expect that the use of retroactive coverage dates will be limited to those circumstances where this is necessary to avoid significant economic harm to consumers.

The coverage effective date for the new QHP will be communicated to the new issuer through HICS if it is different from what the system automatically assigns. The consumer will need to call the former issuer and request a termination to be effective on the day before the new coverage starts.

In the case of a retroactive coverage date or retroactive termination date, the former issuer will repay premiums and reverse claims payments. The gaining issuer would collect premiums for all months of coverage and adjudicate the claims from previous months. With prospective coverage, the consumer's deductible and accumulations towards the maximum out-of-pocket limit would be reset starting with the new date of coverage.

Bulletin #4: Enrollee-Initiated Termination Instructions through the FFM

Enrollees have the right to terminate their coverage in a Qualified Health Plan (QHP) provided they give adequate notice to both the Marketplace and the QHP. Regulatory requirements at 45 CFR §155.430(1) require the Marketplace to permit enrollees to terminate coverage in a QHP. The Centers for Medicare & Medicaid Services (CMS) has developed new functionality on healthcare.gov that allows enrollees to terminate enrollments through the Federally-facilitated Marketplace (FFM). The new functionality on healthcare.gov allows enrollees to select an effective date of termination that can be 14 days from the present date or greater.

CMS allows enrollees to terminate QHP coverage upon request. Upon terminating, individuals will not be able to enroll in a new QHP unless they qualifying for a Special Enrollment Period (SEP).

Note that consumers who are notified that their enrollment has been canceled by the issuer for non-payment of premiums will need to create a new account, complete an application and make a new plan selection. The effective date of coverage will be based on the date of the new plan selection under the regular effective date schedule.

How does an enrollee terminate his/her enrollment through the FFM?

The enrollee logs into their "MyAccount" on the FFM and navigates to the "My plans & programs" tab. The qualified individual then selects the red button labeled "End (Terminate) All Coverage". This will terminate the entire enrollment group. In short, this process will apply when the enrollee is single (enrollment group of 1) or requests termination of the entire enrollment group. If the enrollee would like to terminate less than a full enrollment group, the enrollment group must use the "report a life change" functionality.

How does the issuer process the termination?

The issuer will receive an 834 termination transaction with the effective date of termination indicated.

Going Forward

CMS recognizes that this process does not address all circumstances associated with enrollee initiated terminations through the Federally-facilitated Marketplace. We will address these other termination circumstances in separate guidance.

Examples:

> **Example 1**: An individual enrolls himself and his family with a QHP for January 1, 2014. On February 25th, the individual and his family submit a request to terminate their enrollment and select a termination effective date of March 12, 2014. An 834 termination transaction is sent to the QHP to terminate all the individuals in the enrollment group from their coverage, containing a termination effective date of March 12, 2014.

Example 2: An individual enrolls with a QHP issuer for January 1, 2014. On February 4, the individual terminates her enrollment through the FFM and selects a termination effective date of February 28, 2014. An 834 termination transaction is sent to the QHP to terminate the individual from their coverage, containing a termination effective date of February 28, 2014.

Bulletin #5: Flexibility during the Initial Open Enrollment Period to Change Plans Offered by the Same Issuer at the Same Metal Level

In previous communication with issuers, the Centers for Medicare & Medicaid Services (CMS) had indicated that, once the effective date of an individual's enrollment with an issuer had passed and the first month's premium was paid, that enrollee would not be able to switch Qualified Health Plans (QHPs) without a new enrollment period. This limitation extended to changes both to another issuer and to another plan offered by the same issuer since the FFM enrollment period began. CMS will now allow enrollees to change plans during the Initial Open Enrollment Period after the effective date of their enrollment under certain, discrete circumstances.

What are the circumstances under which this new process would allow an enrollee to change plans?

Individuals who have paid their first month's premium and whose coverage is already effective may change plans provided the change meets ALL of the following criteria:

- Change is to another plan offered by the same issuer,
- Change is to another plan offered at the same metal level and Cost Sharing Reduction (CSR) level, if applicable (i.e. bronze to bronze, silver to silver, 87% actuarial value (AV) silver plan variation to 87% AV silver plan variation, etc.),
- Change is made in order to move to a plan with a more inclusive provider network or for other isolated circumstances determined by CMS, and
- Change is being requested within the Initial Open Enrollment Period.

How do consumers change plans under this new guidance?

The individual who makes a change that meets the criteria above must do so by going to the issuer and the issuer will initiate the plan change. QHP issuers can determine the effective date for the plan change. Issuers may allow retroactive changes. Issuers may also allow for accelerated effective dates. If the issuer does not apply a retroactive or accelerated effective date, then issuers must apply marketplace effective date rules. Issuers must not be discriminatory in implementing plan changes, meaning that they should be consistent in applying effective date rules and treat enrollees in similar circumstances in a consistent manner. The issuer will either cancel or terminate the existing coverage in their system, and activate the new coverage. When determining effective dates, issuers must ensure no break in coverage. The Marketplace will reconcile these plan changes during the formal monthly Reconciliation process.

What do issuers need to do as part of the new process?

Issuers would process the change in plan within their own systems and should not send a termination transaction to FFM. Issuers should document all changes in plans and must be prepared to send the new plan enrollee data to CMS in the same format as the pre-audit file. All out-of-pocket costs incurred by the enrollee in the initial plan should be credited towards the deductible and annual maximum out-of-pocket cost limit in the new plan.

What do issuers do about changes in APTC or CSRs as a result of a plan change?

Because eligibility is not being re-determined for enrollees, advance payment of the premium tax credit (APTC) amounts will not change. Advanced CSR amounts will change as CSR amounts are QHP-specific. CMS is currently collecting information from issuers to make APTC and advanced CSR payments. Issuers should include enrollees that change plans under this policy modification in the new plan in their request to CMS for payments. When payment system functionality is available, CMS will make payments based on updated information provided through the monthly reconciliation process.

Examples:

Example 1: An individual enrolls in an issuer's silver plan on November 28th for a January 1st effective date. On February 8th, the enrollee discovers that a specialist that he/she sees is not part of the network for that plan. Additionally, the enrollee discovers that the issuer offers another silver product with a more expansive network that includes the specialist he/she wants to see. The enrollee calls the issuer and asks to change plans. If completed before February 15th and the issuer chooses to apply Marketplace rules to all such changes, the change would be effective for March 1st. If completed after February 15th but on or before March 15th, the change would be effective April 1st.

Example 2: Same as *Example 1*, except after contacting the issuer on February 8th, the enrollee completes changing plans with the issuer on February 11th. The change would be normally effective for March 1st under Marketplace rules for determining effective dates. However, the issuer allows enrollees making this type of change to choose a retroactive effective date. The enrollee chooses to change for January 1st. In addition to retroactively cancelling the first enrollment back to January 1st, the issuer makes coverage in the newly selected plan effective for January 1st. The issuer must transfer all claims made on the cancelled enrollment to the new enrollment and must apply the new cost sharing as appropriate. Additionally, the issuer will then recalculate any progress towards any out-of-pocket maximum that applies to the new enrollment.

Example 3: Same as *Example 1*, except the product with the provider network that includes the specialist in question is a gold metal level product. The individual could not make the change using this functionality because the metal level is different from that of the product in which he initially enrolled. He will have to wait for either the Annual Open Enrollment Period (OEP) or a valid Special Enrollment Period (SEP).

Example 4: Same as *Example 1*, except the individual does not attempt to make the change until May 4th. Without a valid SEP, the individual could not make the change because the Initial Open Enrollment Period is over.

Bulletin #6: Clarifications of the Instructions Presented in the December 17, 2013, Interim Final Rule and Bulletin #001

CMS published an Interim Final Rule[4] (IFR) on December 17, 2013 outlining several policies related to coverage effective dates and premium payments to QHPs. Subsequent to publishing the IFR, CMS published Bulletin #001 on December 20, 2013 aligning the Draft Enrollment Guidance with the December 17, 2013 Interim Final Rule (IFR). This bulletin clarifies instructions provided in both the December 17, 2013 IFR and Bulletin #001.

Premium Payment Due Date

Since the release of the IFR and Bulletin #001, issuers have requested additional clarification regarding the parameters for establishing the due date for the first month's premium when coverage is granted for a retroactive effective date. The IFR established that QHP issuers in the FFM must establish due dates for payment of the initial month's premium **no earlier than** the day before coverage becomes effective during the Initial Open Enrollment Period.

In instances where issuers are processing retroactive enrollment, CMS expects issuers to provide a due date for the first month's premium that is reasonably achievable by the enrollee. CMS believes that a date that is at least seven (7) calendar days after the date that the issuer receives both the 834 enrollment transaction and the concurrent HICS record establishing the retroactive effective date granted on the basis of an approved Marketplace SEP would be reasonably achievable.

Examples
The following examples illustrate different applications of this policy.

> **Example 1:** A consumer contacts the Marketplace's call center on January 13, 2014. He indicates that he attempted to enroll in November, 2013, for a January 1, 2014 effective date, but that the issuer with whom he attempted to enroll has no record of the enrollment. On the basis of an approved Marketplace Error SEP, the CMS call center representative enrolls the individual in the desired QHP. Then the Marketplace sends an 834 enrollment transaction to the issuer with a 2/1/2014 effective date (based on the January 13, 2014 selection). The call center representative then creates an entry in HICS establishing that the enrollment should have a 1/1/2014 effective date, and links the HICS entry to the issuer's queue. The issuer downloads the HICS data and receives the 834 enrollment transaction on 1/14/2014 and enrolls the individual for 1/1/2014 per the HICS entry. Then the issuer sends a bill to the enrollee for the first month's premium and indicates a due date of 1/21/2014. The consumer now has until 1/21/2014 to pay the first month's premium in order to keep the coverage that was started retroactively for 1/1/2014.
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> **Example 2:** Same as *Example 1*, except the premium due date on the bill is 1/17/2014. In this case, the issuer has created a premium due date for the first month's premium that is

[4] Maximizing January 1, 2014 Coverage Opportunities: http://www.gpo.gov/fdsys/pkg/FR-2013-12-17/pdf/2013-29918.pdf

less than seven (7) days after 1/14/2014 which is the date that the issuer received the 834 enrollment transaction. CMS does not believe that this would be a reasonably achievable date that would satisfy the requirements of the premium payment date regulation.

Example 3: Same as *Example 1*, but the issuer assigns a premium due date of 1/31/2014. In this case, the issuer has created a premium due date for the first month's premium that CMS believes would be reasonably achievable, as 1/31/2014 is greater than seven (7) days after 1/14/2014 which is the date that the issuer received the 834 enrollment transaction.