

Federally Facilitated Marketplace Enrollment Operational Policy & Guidance

October 3, 2013

This draft manual will go into effect with minimal changes as of October 1, 2013. All enrollments made on or after October 1, 2013, must be processed in accordance with these requirements.

It is CMS’ intention that this will be a living document, updated regularly, and supported by clarifying bulletins in the interim between updates. To that end, CMS solicits comments on this document. In order to submit comments, please use the comment form posted with this manual on REGTAP (<https://www.REGTAP.info>). Please e-mail all comments to EnrollmentGuidance@cms.hhs.gov with “Comments on Enrollment Manual” in the subject field.

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1.0 Introduction and Scope

The information provided in this document applies to entities that have a role in the enrollment process, including, but not limited to:

- The Federally-facilitated Marketplaces (FFMs)ⁱ
- The Federally-facilitated Small Business Health Options Programs (FF-SHOPs)
- Qualified Health Plans (QHPs)
- Agents and Brokers (A/B)
- Third-Party Administrators (TPAs)
- Trading Partners such as Clearinghouses

Where necessary, we have identified whether this operational policy and guidance pertains to the FFMs and FF-SHOPs, just the FFMs, or just the FF-SHOPs. Additionally, we have indicated where necessary that the policy and guidance pertain to both QHPs and Marketplace-certified stand-alone dental plans, which this document will refer to as qualified dental plans (QDPs).

1.1 Types of Marketplaces

Section 1311(b)(1) of the Affordable Care Act and 45 CFR §155.410(c)(i) require Marketplaces in every state to begin offering coverage that is effective starting no later than January 1, 2014. Section 1321(c)(1) of the Affordable Care Act directs the Secretary of Health and Human Services (the Secretary) to establish and operate a Federally-facilitated Marketplace (FFM) in any state that does not elect to operate a State-based Marketplace (SBM), or that the Secretary determines will not have an operable Marketplace for the 2014 coverage year.

The FFMs will assist qualified individuals (QIs) with purchasing affordable health insurance coverage or obtaining an eligibility determination or eligibility assessment for coverage under Medicaid or the Children's Health Insurance Program (CHIP). The SHOPs will assist qualified employers with offering affordable health insurance coverage to their employees. In addition to the FFMs and SBMs, there are State Partnership Marketplaces (SPMs), which are FFMs in which a state engages actively with the federal government in the operation of certain aspects of the FFM directly established and operated by the federal government in that state. In SPM states, the federal government is responsible for all Marketplace eligibility and enrollment functions. Beginning in 2014, some states may operate a SHOP-only Marketplace with the Federal government operating an individual market FFM. In 2015, all states will have this option.

In order to enroll in coverage through the FFMs, individuals complete a single streamlined application (pursuant to 45 CFR §155.405) to determine both their eligibility to purchase coverage through the Marketplace and, if the applicant chooses to apply, for insurance affordability programs including advance payments of the premium tax credit (APTC), cost-sharing reductions (CSRs), Medicaid, and CHIP. Depending on a state's election, the FFM will either make final determinations of eligibility for Medicaid and CHIP based on modified adjusted gross income (MAGI), or assessments of potential eligibility for Medicaid and CHIP based on MAGI. In an assessment state, the state Medicaid/CHIP agencies will make the final eligibility determinations for individuals assessed as potentially eligible by

the FFM. In all states, the FFMs will screen applicants for potential eligibility for Medicaid based on criteria other than MAGI, and will refer applicants screened as potentially eligible on a basis other than MAGI to the state Medicaid agency for a full eligibility determination. Applicants who believe they may be eligible for Medicaid on a basis other than MAGI may also request that their applications be transferred to the state Medicaid agency for a full eligibility determination.

If an individual is determined qualified to purchase coverage through an FFM, the QI can compare available QHPs, and if applicable, available QDPs. The QI then selects a QHP and a QDP, if applicable. If the QI applied for financial assistance and is eligible, he or she can select between \$0 and the maximum APTC for which he or she is eligible. If the QI is eligible for CSRs, he or she will be shown plan variations that reflect the cost-sharing levels applicable to him or her. Once the QI selects a QHP and QDP, if applicable, the FFM electronically provides enrollment information to the QHP and QDP.

In order to enroll in coverage through a SHOP, employers and employees must complete applications as required by 45 CFR §155.715(b) to determine their eligibility for coverage. If eligible for coverage, the qualified employer can decide upon a coverage option to offer to its qualified employees.

In 2014, the FF-SHOPs will provide qualified employers with the option of selecting a single QHP (plus a QDP, if they desire) to offer their employees. Beginning in 2015, all SHOPs must permit a qualified employer to offer all plans within a single metal level of coverage to its qualified employees. Qualified employers participating in the FF-SHOPs will be able to choose between offering their employees all QHPs at a single metal level of coverage or offering them only a single QHP (plus a QDP, if they desire). Once an employer enrolls through a SHOP and employees elect to accept the employer's offer of coverage, the SHOP will electronically provide enrollment information to the appropriate QHP issuer(s).

1.2 Initial and Annual Open Enrollment Periods and Coverage Effective Dates

The initial open enrollment period in all individual market Marketplaces begins October 1, 2013, and lasts until March 31, 2014, as required by 45 CFR §155.410(b). Coverage effective dates are based on a QI's QHP selection date and begin as early as January 1, 2014. In 2014, and subsequent years, annual open enrollment for the following coverage year will occur between October 15 and December 7. However, 45 CFR §155.310(c) specifies that the Marketplace must accept an application and make an eligibility determination at any point in time during the year, which will enable individuals to learn whether they are eligible for a special enrollment period (SEP) for Marketplace coverage, or for Medicaid or CHIP, for which there are no restrictions on when an individual can enroll.

Table 1A illustrates coverage effective dates based on the initial open enrollment period and subsequent annual open enrollment periods for individual market enrollment.

Table 1A – Individual Market Coverage Effective Dates (Initial and Annual Open Enrollment Period) for ALL individual market Marketplaces

Plan Selection Date	Coverage Effective Date
October 1, 2013 through December 15, 2013	January 1, 2014
Between the 1 st and 15 th day of the month (Between January 1, 2014 and March 15, 2014)	First day of the following month
Between the 16 th and last day of the month (Between December 16, 2013 and March 31, 2014)	First day of the second following month
October 15 th through December 7 th (Beginning in October 2014 and for all subsequent years)	January 1 of the following year

Initial open enrollment in the FF-SHOP begins October 1, 2013 as designated by 45 CFR §155.725(a)(1) and 45 CFR 155.410(b). Coverage effective dates will be based on a date selected by the qualified employer as part of the application and enrollment process. If qualified employers offer coverage, their qualified employees accept the offer and the employer completes the enrollment process, on or before December 15, 2013, the employees will have coverage effective on January 1, 2014. After January 1, 2014, qualified employers may submit applications at any point throughout the year for coverage starting on the 1st of the subsequent month. Employers must complete the enrollment process by the 15th of any month for coverage to take effect on the 1st of the following month otherwise the coverage will be effective the 1st of the second following month. For example, if an employer completes the enrollment process by February 16, 2014, the group’s coverage will be effective April 1, 2014.

An employer’s plan year lasts for 12 months. Open enrollment and renewal periods will occur on a rolling basis throughout the year. Pursuant to 45 CFR 155.725(c) and (e), there will always be a period of at least 30 days prior to the completion of a plan year for the employer to decide whether to renew its selected coverage option, and there will always be a subsequent period of at least 30 days for employees to decide whether they want to renew or change their coverage.

Three (3) months before the end of an employer’s plan year, the FF-SHOP will send an employer a renewal notice. Employers will have 30 days to review their offer of coverage. After this period has elapsed, if the employer has decided to continue offering coverage to employees through the SHOP, the SHOP will notify the employer’s employees about their coverage options for the subsequent year. Employees will have at least 30 days to review the new offer of coverage and decide to either accept the offer of coverage or waive the offer of coverage. During this open enrollment period, employees may also add eligible dependents and make changes to their QHP or QDP plan selection (if an employer has made employee choice available to qualified employees). The group’s renewal (both the employer’s plan offerings and employee coverage decisions) must be submitted by the 15th of the month prior to the end of the employer’s plan year to be effective timely for the beginning of the following plan year. For example, an employer enrolling on June 1, 2014, for coverage in the FF-SHOP will receive a renewal notice from the SHOP March 1, 2015. The employer will then have until the end of March to review its offer of coverage and make any changes for the next 12 month plan year. By April 1, employees will be notified by the FF-SHOP of the updated offer of coverage. They will have until the end of April to either accept the offer of coverage or waive the offer of coverage. The final renewal decision is made by the employer. The employer must confirm renewal after the employers confirm coverage. This must occur by May 15, 2015, for coverage to remain in effect for the next 12 months. The time between the end of

the employee renewal deadline and the 15th of the month prior to the beginning of the next plan year allows for additional time to ensure the renewal is processed in time. If an employer misses this deadline, it may reapply for coverage. An employer unable to meet the FF-SHOP's minimum participation rate upon renewal may not be able to renew coverage and, in such case, could submit a new application for determination of eligibility at another time during the year when the employer could meet the minimum participation rate, or between November 15 and December 15, pursuant to the standards described in 45 CFR §147.104. Table 1B illustrates coverage effective dates for the FF-SHOP.

Table 1B – FF-SHOP Coverage Effective Dates (Initial Enrollment Periods)

Plan Selection Date	Coverage Effective Date
October 1, 2013 through December 15, 2013	January 1, 2014
Between the 1 st and 15 th day of the month (Beginning January 1, 2014)	First day of the following month
Between the 16 th and last day of the month (Beginning December 16, 2013)	First day of the second following month

Table 1C – Coverage Effective Dates for Individuals during Initial and Annual Open Enrollment

Triggering Event	Enrollment Period Start Date	Enrollment Period End Date	Plan Selection Date Range	Coverage Effective Dates (first available date depending on the plan selection date)
Initial Open Enrollment Period	10/1/2013	3/31/2014	10/1/2013 – 12/15/2013	1/1/2014
Initial Open Enrollment Period	10/1/2013	3/31/2014	12/16/2013 – 1/15/2014	2/1/2014
Initial Open Enrollment Period	10/1/2013	3/31/2014	1/16/2014 - 2/15/2014	3/1/2014
Initial Open Enrollment Period	10/1/2013	3/31/2014	2/16/2014 – 3/15/2014	4/1/2014
Initial Open Enrollment Period	10/1/2013	3/31/2014	3/16/2014 – 3/31/2014	5/1/2014
Annual Open Enrollment Period (for 2014 and subsequent years)	10/15/YYYY	12/7/YYYY	10/15/YYYY – 12/7/YYYY	1/1/YYYY

Table 1D – Coverage Effective Dates for FF-SHOP Initial and Annual Open Enrollment

Triggering Event	Enrollment Period Start Date	Enrollment Period End Date	Group Submission Date	Coverage Effective Dates (first available date depending on the group submission date)
Initial Open Enrollment Period	10/1/2013	12/15/2013	12/11/2013	1/1/2014
Initial Open Enrollment Period	10/1/2013	12/15/2013	12/18/2013	2/1/2014
Initial Open Enrollment Period	6/16/2014	7/15/2014	7/7/2014	8/1/2014
Initial Open Enrollment Period	6/16/2014	7/15/2014	7/16/2014	9/1/2014
Annual Open Enrollment Period (for 2014 and subsequent years)	6/1/YYYY [renewal for plan year beginning of the year prior to the coverage year]	8/15/YYYY	8/5/YYYY	9/1/YYYY
Annual Open Enrollment Period (for 2014 and subsequent years)	2/1/YYYY [renewal for plan year beginning of the year prior to the coverage year]	4/15/YYYY	4/7/YYYY	5/1/YYYY

Minimum Participation Rates in SHOP

SHOPS may authorize the use of minimum group participation requirements, if permitted by state law. This means that in SHOP, a minimum percentage of employees offered the plan must enroll in the plan, in order to comply with the requirement. A small employer's ability to enroll through the SHOP may be restricted to a limited enrollment period (November 15th - December 15th) if the employer fails to meet the requirement.

The default minimum participation rate in an FF-SHOP is 70%. If there is evidence that the state has set a different rate by statute/regulation, or if there is evidence that issuers commonly use a different rate, the FF-SHOP may use the state-specific rate. For the FF-SHOP, employees who are covered by another employer group health plan, a public insurance program such as Medicare or Medicaid, or a health plan

for enlisted military personnel and military dependents, such as TriCare, are excluded from the calculation. However, individuals purchasing insurance in the non-group private market (including the individual Marketplace) will be included in the FF-SHOP's calculation of a group's minimum participation rate.¹

The FF-SHOPs will determine if a group meets the minimum participation requirement before sending any enrollment transactions to issuers. The minimum participation rate will be calculated only upon initial enrollment and renewal. The participation rate will not be calculated for groups initially enrolling between November 15 and December 15 pursuant to the standards described in 45 CFR §147.104. Mid-year fluctuations in a group's participation rate will not affect its eligibility for coverage through the FF-SHOP. If at the time of application or renewal, an employer does not meet the FF-SHOP's minimum participation rate but thinks that it could meet the rate if it modified its offer of coverage to its employees, the employer may revise its offer to encourage more employees to enroll. An employer unable to meet the FF-SHOP's minimum participation rate upon renewal not be able to renew coverage and, in such case, could submit a new application for determination of eligibility at another time during the year when the employer could meet the minimum participation rate, or between November 15 and December 15, pursuant to the standards described in 45 CFR §147.104.

Retirees

The FF-SHOP allows for coverage of retirees. This information will be reported on 834 enrollment transactions under the category of retirees. As currently designed, all employees (part-time and full-time), business owners, and retirees on the employee roster are treated in a similar manner. Thus, retirees will not receive a different contribution amount through the FF-SHOP from other enrollees. All retirees, active employees, and dependents will be rated using the same age curve. Because retirees will be on the employer's roster of eligible enrollees, they will be included in minimum participation rate calculations.

2.0 Enrollment Transactions in the Marketplace

45 CFR §155.270 requires all Marketplaces to use standards, implementation specifications, operating rules, and code sets adopted by the Department of Health and Human Services (HHS) under the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA) when conducting certain electronic transactions with a covered entity, such as a QHP issuer.

The Marketplaces and both QHP and QDP issuers will exchange enrollment transactions in files using the Accredited Standards Committee (ASC) X12 834 Benefit Enrollment and Maintenance Version 5010, adopted by the Secretary on January 23, 2009.

CMS released a Companion Guide to explain how certain new data elements, such as APTC and CSR data in the FFMs, and employer and employee premium contributions in the FF-SHOPs, will be included in the existing version of the ASC X12 834 enrollment transaction. Issuers offering QHPs and QDPs through the

¹ Please see 45 CFR §155.705(b)(10) and 78 FR 15503.

FFMs or FF-SHOPs must use the ASC X12 834 in combination with the CMS Enrollment Companion Guide for purposes of enrollment transactions.

On rare occasions (e.g., natural disasters or serious technical problems), it may be necessary to transmit an enrollment file in a non-electronic data interface (EDI) format. For the FFMs and FF-SHOPs, CMS will work with QHP and QDP issuers to evaluate and determine appropriate alternate paths to securely transmit enrollment data, which may include CDs, tapes, or online processes, as necessary and appropriate. These alternate methods must still follow the appropriate security measures to ensure the protection and privacy of enrollee information.

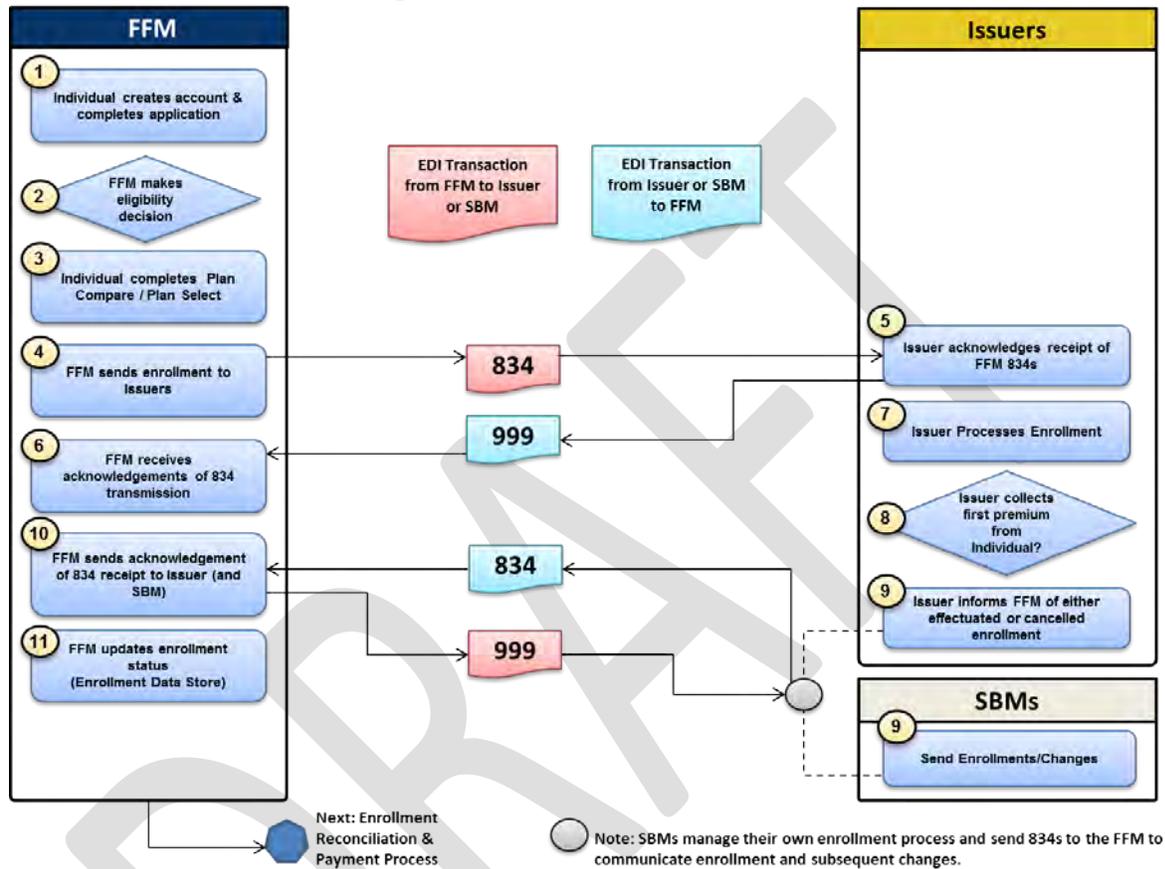
Enrollment transactions in FF-SHOPs consist of two independent transactions between an FF-SHOP and QHP or QDP issuers (group enrollment transactions and ASC X12 834 enrollment transactions). Employer Group Enrollment is the transaction through which the Marketplace will transmit to issuers detailed information regarding the employer offering group coverage through the FF-SHOP. Because no existing standard exists for transmitting detailed employer information to a health insurance issuer, CMS has defined a method in an Employer Group Business Services definition. Information including the specification for the form and manner of the information transmitted can be found in the Companion Guide.

For purposes of transmitting enrollment information to the QHP and QDP issuers, the FFMs and FF-SHOPs will transmit daily electronic files to the issuers or their trading partners in the adopted ASC X12 Version 5010 for enrollment (834). Errors will be reported using the ASC X12 acknowledgement transactions, including the TA1 and the 999, for syntax and content. This information is explained in more detail in the CMS Companion Guide, available on the CMS website at <http://www.cciio.cms.gov>.

2.1 The Enrollment Process in the FFM

Figure 2A below depicts a high-level end-to-end system flow of the FFM and FF-SHOP process for enrolling in a QHP and QDP. Please refer to Figure 2A when reviewing the enrollment instructions in the succeeding sections.

Figure 2A – FFM Enrollment Process



2.2 Initial 834 Enrollment Transaction

In the FFMs, once a QI selects a QHP and QDP if desired, the FFM generates an ASC X12 834 enrollment transaction to the issuer. The FFM will accumulate transactions and send them once each day (7 days a week, except during scheduled maintenance windows).

If a QI makes a plan selection and subsequently makes a change later in the same day before daily transactions are submitted, the plan selection and the change will each generate separate 834 transactions, and issuers will need to process each transaction in sequence.

In the FF-SHOPs, once a qualified employer completes the enrollment process, the FF-SHOP generates a group enrollment transaction and an 834 enrollment transaction. Unlike the FFMs, which will batch and send associated individual employee 834 transactions once per day, group enrollment transactions are never batched and are transmitted throughout the day. The FF-SHOPs will send transactions 7 days a week, except for scheduled maintenance windows.

2.3 Premium Payment

Individual Market Payment Redirect

On the Marketplace website, once the QI confirms the plan selection(s), the FFM will provide the QI a link to the issuer's payment site if the issuer provided a payment site in its QHP application. If plans from more than one issuer are selected, then there would be multiple payment redirects, each redirect occurring in a separate window. This FFM service is referred to as payment redirect.

In the FFMs, all QIs will be advised to contact the QHP or QDP's customer service for payment issues.

Payment redirect will typically occur before an FFM generates the 834 enrollment transaction to the QHP issuer. Therefore, at the time of payment redirect, the QHP issuer will often not have any information on file regarding plan selection and, if eligible, the APTC amount selected. During payment redirect, the FFM will electronically transfer a minimum set of information necessary for the QHP issuer to accept payment, including subscriber information, plan selection, the QI's portion of premium due, and the amount of APTC applied to the premium (for a complete description of Payment Redirect, see SBS-EXCH-EE: 209 Payment Redirect to Issuer Payment Portal Business Service Definition posted on REGTAP.info).

QHP issuers may, but are not required to, accept payment online at the time of payment redirect. CMS considers it to be a best practice to accept payment immediately to expedite a confirmed enrollment. If a QHP issuer is not capable of accepting online payment at the time of redirect, or elects not to do so, CMS will provide standard language to QIs that the issuer will bill them for premium payment.

The FFM will provide the QI with the payment redirect link until the FFM has received either an 834 enrollment confirmation transaction from the issuer indicating the initial month's premium has been paid, or has received an 834 cancellation transaction from the issuer.

Example 2A: A QI confirms his or her plan selection on November 15, and makes payment online the same day by being redirected to the issuer's payment site.

Example 2B: A QI confirms his or her plan selection on November 15 but does not use the redirect to pay online. The FFM sends the issuer the 834 enrollment transaction on November 15, and the issuer bills the QI on November 21. When the QI receives the invoice, he or she decides to log in to the FFM. The payment redirect link is still available to the QI because the proposed effective date (January 1) has not lapsed and the FFM has not received the confirmation/effectuation 834 transaction.

Example 2C: A QI confirms his or her plan selection on November 15 but does not use the redirect to pay online. The FFM sends the issuer the 834 enrollment transaction on November 15, and the issuer bills the QI on November 21. The QI pays on November 30, and the FFM receives a confirmation/effectuation 834 transaction from the issuer on December 2. When the QI logs back into the FFM on December 5, the payment redirect link will not be active (because the FFM has received the confirmation/effectuation 834 transaction already).

Example 2D: A QI confirms his or her plan selection on November 15 but does not use the redirect to pay online. The FFM sends the issuer the 834 enrollment transaction on November 15, and the issuer bills the QI on November 21. The QI does not pay upon receipt of the invoice, and logs into the FFM on January 2. The payment redirect is not available because the proposed effective date has lapsed. Because payment has not been made prior to the effective date of coverage, the issuer sends a cancellation transaction to the FFM. Since the initial open enrollment period does not end until March 31, 2014, in this specific example, the QI would still be able to select another plan (or the same plan again) for an effective date as early as February 1, 2014.

If a QI completes plan selection via the FFM Call Center, or in any case when the QI is not redirected online to the QHP issuer to make an initial premium payment, the QI may contact the selected QHP issuer to arrange payment (typically by phone) before the QHP issuer receives the 834 enrollment transaction from the FFM. CMS expects the QHP issuer to have its customer service staff equipped with telephonic scripts to handle such calls.

Once a QI has paid his or her portion of the premium and the issuer has sent a confirmation file to the FFM, the issuer must send the enrollee an enrollment information package consistent with 45 CFR §156.265(e). Appendix B includes an example of the content an issuer might consider including in the cover letter as part of the enrollment package.

FF-SHOP

Employers participating in FF-SHOPS will also be offered payment redirect if the QHP they selected offers online payment; employers pay the sum of the first month's premiums for each employee electing coverage.

If the QHP issuer has provided a FF-SHOP with the information necessary to redirect a qualified employer to its payment portal, once the qualified employer confirms its plan selection, in addition to generating 834 enrollment and group enrollment transactions, the FF-SHOP will also provide the qualified employer a link to the issuer's payment portal in the same shopping experience. In 2015, when employee choice is available to employers enrolling in the FF-SHOPS, the payment redirect will always be to the FF-SHOP's premium aggregation vendor, in which case the employer may not pay an issuer directly for FF-SHOP coverage.

In cases where payment redirect is available, a qualified employer is redirected online to the issuer's payment site via a web link. Payment redirect will typically occur after the FF-SHOP has initiated the transmission of the group enrollment data to the QHP issuer and may occur before 834 transactions are transmitted to the QHP issuer. During payment redirect, the FF-SHOP will electronically transfer a minimum set of information necessary for the QHP issuer to accept payment, including the group's information, plan selection, and notification of the qualified employer's and employees' portions of premium due (for a complete description of Payment Redirect, see SBS-EXCH-EE: 209 Payment Redirect to Issuer Payment Portal Business Service Definition).

QHP issuers in the FF-SHOPS and the FFMs may, but are not required to, accept payment online at the time of payment redirect. CMS considers it a best practice to accept payment immediately to expedite a

confirmed enrollment. If a QHP issuer is not capable of accepting online payment at the time of redirect, or elects not to do so, CMS will display contact information for the issuer's billing department and explain to the qualified employer that the issuer will bill the qualified employer for premium payment.

The SHOP payment redirect page will contain the following information:

- The methods of payment the QHP issuer will accept, such as credit cards, pre-paid debit cards, automatic bank account deduction, paper checks, and/or money orders
- Ways the qualified employer can contact the QHP issuer, such as a toll-free customer service number, in order to make arrangements for payment of their portion of the initial month's premium
- That the qualified employer must make payment of their portion of the initial month's premium before their coverage effective date in order to have their enrollment effectuated

If a qualified employer completes plan selection via the FF-SHOP Employer Call Center, or when the qualified employer is not redirected on line to the QHP issuer payment portal to make a payment, the qualified employer may contact the QHP issuer to arrange payment before the QHP issuer receives the 834 enrollment transaction from the FFM. CMS expects the QHP issuer to have their customer service staff equipped with telephonic scripts to handle such calls.

Premium Payment Methods in the Individual Market

QHP issuers are required to accept paper checks, cashier's checks, money orders, electronic funds transfer (EFT), and all general-purpose pre-paid debit cards (including those issued by state agencies for the purpose of paying for benefits including healthcare) as methods of payment in the individual market. Further, according to 45 CFR §156.1240(a)(2) the QHP issuer must present all payment method options equally for a QI to select his or her preferred payment method.

QHP issuers may accept payment of the initial premium by a method that is exclusive to the initial premium. For example, payment redirect may allow payment of the initial month's premium by credit card, even though the issuer does not accept credit cards as a method of payment for regular, monthly premiums.

Application of premium payment methods must not discriminate against any QI or group of QIs. Issuers may not offer a discount on premiums to individuals who elect a specific type of premium payment method (e.g. EFT). Additionally, issuers may not apply additional fees to a QI based on his or her choice of valid payment method. For example, an issuer may not pass on administrative fees for processing a premium payment via credit card.

Premium Payment Threshold in the Individual Market

In the FFM individual market, QHP issuers may implement a premium payment threshold policy in their FFM products. QHP issuers electing to establish such a policy may effectuate enrollment when the enrollee pays an amount less than the total amount owed by the enrollee but greater than the threshold amount established by the issuer. We anticipate this is mostly likely to occur when enrollees transpose numbers and underpay by less than a dollar. We recommend that if issuers choose to implement a threshold that it be based on a percentage of the enrollee-responsible portion of the overall premium (total premium minus APTC equals the enrollee-responsible portion). We recommend a percentage equal to or greater than 95%.

Consistent with rating rules that must be standard and consistent, QHP issuers that choose to apply a payment threshold policy should apply them equally across all enrollees. Additionally, the policy may be applied to both the initial premium payment and/or any subsequent premium payments. When an enrollee has paid within the premium threshold but has not paid the full enrollee-responsible-portion of the premium, the enrollee still owes the balance. If the enrollee has paid the initial premium within the threshold’s tolerance percentage but has not paid the full amount, the QHP issuer can still effectuate the enrollment. If the enrollee makes subsequent premium payments within the threshold’s tolerance but has not paid the full amount due, the QHP issuer may consider the enrollee to be current on all payments due for the purpose of determining whether to place the enrollee into an applicable non-payment grace period. If the enrollee continues paying an amount less than the owed amount including past due premiums, the owed amount will accumulate and may increase beyond the threshold amount. If that is the case, the enrollee’s account has become past-due and the enrollee will be subject to the grace period for failure to pay premiums.

If an enrollee fails to make payment within the threshold tolerance, and is placed in the applicable grace period, the payment threshold does not apply, and the enrollee must pay all past due premium amounts before the end of the applicable grace period to avoid termination for non-payment of premium.

Table 1E – Premium Payment Threshold Lifecycle

Date	Action	Comments
12/10/2013	Qualified Individual selects Plan (\$100 enrollee Portion after APTC).	Premium payment threshold of 95%
12/16/2013	Enrollee Billed \$100 for January Coverage.	
12/28/2013	Enrollee Pays \$97 for January Coverage.	Within Tolerance and coverage effectuated on 1/1/2014.
1/16/2014	Enrollee Billed \$100 for Feb Coverage and \$3 past due from January.	Total amount billed \$103.

Date	Action	Comments
2/1/2014	Enrollee Pays \$97.	\$3 Applied to January coverage, \$94 applied to February coverage. The \$94 is not within tolerance, so the issuer places the enrollee into the grace period due to his or her delinquency status as of February 1. January is paid in full. February is \$6 past due.
2/16/2014	Enrollee Billed \$100 for March Coverage and \$6 past due from February.	Total amount billed \$106.
3/16/2014	Enrollee Billed \$100 for April Coverage and \$100 from March and \$6 past due from February.	Total amount billed \$206. No payment received from enrollee.
4/16/2014	Enrollee Billed \$100 for May Coverage and \$100 from April, \$100 from March, and \$6 past due from February.	Total amount billed \$306. No payment received from enrollee.
4/25/2014	Enrollee Pays \$202	\$6 is applied to February (paid in full), \$100 is applied to March (paid in full), \$96 is applied to April (enrollee still in grace period).
4/30/14	Enrollee makes no payment	No payment received by 4/30/2014. If the enrollee does not pay \$4 by 4/30/2014, then he or she will be terminated effective 2/28/2014.
5/1/14	Issuer refunds \$196 to enrollee. Enrollee terminated for failure to pay premiums effective 2/28/2014.	If the enrollee had paid the \$4, he or she would still owe \$100 for May 2014. If he or she failed to pay that bill within the threshold by the due date, the grace period would start again.

2.4 Relationship between Premium Payments and the Confirmation/Effectuation 834 Transaction

In the FFM, once an issuer receives either full payment or payment within the premium payment threshold (if the issuer utilizes a premium payment threshold) for any applicable initial premium due from the QI, and the issuer has received the initial 834 enrollment transaction, the issuer will send the FFM a full ASC X12 834 effectuation/confirmation transaction. For simplicity, in the remainder of this document, this transaction will be referred to as the confirmation transaction. The confirmation transaction provides the FFM assurance that the issuer has effectuated enrollment. Issuers do not have the ability to grant grace periods for payment of the initial month's premium. The issuer must receive full payment (or payment within the premium payment threshold if the issuer utilizes such) from the QI for any applicable initial premium no later than the day before the coverage effective date, which is established based on the date of plan selection. For the purpose of enrollment in a QHP, payment can be considered received when an electronic funds transfer (EFT) is completed, a credit or debit card transaction is processed, or paper checks/money orders are in the issuer's possession, i.e. as received and logged in the issuer's mailroom. Issuers may not apply de-minimis rules regarding payment of the initial month's premium. The QI's portion of the premium payment must be made in full (or paid within the premium payment threshold if the issuer utilizes such).

Example 2E: A QI selects a QHP on 12/12/2013 and therefore is assigned a coverage effective date of 1/1/2014. The full monthly premium for the selected plan is \$300 and the issuer does not make use of a premium payment threshold. The enrollee is qualified for a maximum APTC of \$125 per month. The enrollee elects to receive the full APTC amount of \$125. Therefore the 834 enrollment transaction indicates the full monthly premium of \$300, the monthly APTC amount of \$125, and the \$175 enrollee-responsible portion of the monthly premium. The enrollee mails the \$175 payment on 12/31/2013. The issuer does not receive the payment until 1/4/2014. The issuer cannot effectuate enrollment by sending the confirmation file. No coverage is granted on 1/1/2014. Additionally, any premium paid is refunded and any advance payments of the APTC paid on the behalf of the enrollee must be returned to the FFM.

Example 2F: Same circumstances as example 2E, except the enrollee mails a payment of only \$100, but does so on 12/16/2013. The issuer receives the payment on 12/19/2013. The enrollee makes no further payment towards the initial month's premium. Although payment was received by the issuer prior to the coverage effective date, because the enrollee did not make payment in full, the issuer cannot effectuate enrollment by sending the confirmation file. No coverage is granted on 1/1/2014 and any advance payments of the APTC paid on the behalf of the enrollee are refunded.

Example 2G: A QI selects a QHP on November 2, 2013 and is therefore assigned a coverage effective date of January 1, 2014. The monthly premium is \$200 and the issuer does not make use of a premium payment threshold. The QI is eligible for a maximum APTC of \$75 per month. The QI selects the maximum APTC and therefore is responsible for a monthly premium payment of \$125. The QI is therefore required to make payment of initial month's premium of \$125 to the QHP issuer no later than December 31, 2013. The QHP issuer receives payment of \$125 from

the QI on December 31, 2013. The QHP issuer then sends the FFM the 834 confirmation transaction on January 2, 2014. The QHP issuer has met the FFM's expectation for timely transmission of the confirmation transaction

Issuers should not wait to confirm enrollment of an individual until after APTC is paid. For purposes of generating the confirmation transaction, full payment occurs when the issuer receives full payment (or payment within the premium payment threshold if the issuer utilizes such) of the portion of the premium for which the enrollee is responsible. We realize that some enrollees will wait until just prior to their coverage effective date to make payment, and therefore issuers may receive payments the day prior to the enrollee's coverage effective date. In such circumstances issuers may not be able to transmit all confirmation transactions prior to the coverage effective date. However, the FFM expects QHP and QDP issuers to send all confirmation transactions by the fifth calendar day of the effective month of coverage.

Example 2H: Same circumstances as example 2G, except the QHP issuer transmits the 834 confirmation transaction on January 7, 2014. The QHP issuer has not met the FFM's expectation for timely transmission of the confirmation transaction.

In the FF-SHOPS, once a qualified employer submits payment to the issuer for the initial premium due, the issuer will send the FF-SHOP a full 834 confirmation transaction. The confirmation transaction provides the FF-SHOP assurance that the issuer has effectuated enrollment consistent with the information received on the initial enrollment transaction from the FF-SHOP.

Payment for any applicable initial premium from the qualified employer must be received by the QHP issuer no later than the day before the coverage effective date, which is established, based on the date of the employees' plan selection.

2.5 Cancellations

A Cancellation transaction is a withdrawal of a plan selection for health insurance coverage before the effective date of coverage. Cancellations can be initiated by the issuer or the applicant.

Cancellation transactions initiated by the QI/enrollee are voluntary and must be submitted through the FFM with whom he or she enrolled. A QI/enrollee may choose to cancel coverage for any reason. For instance, the individual may no longer want or need health insurance coverage through the FFM because he or she has gained other coverage, or he or she may have changed his or her mind within an enrollment period about the QHP or QDP he or she selected and wish to select a different available QHP or QDP.

A QI/enrollee must complete submission of his or her cancellation request to the FFM or FF-SHOP by 11:59 PM on the date prior to the coverage effective date. An individual enrolled in an FFM cannot request a cancellation after his or her coverage effective date unless the enrollee is in a Free Look period. (See section 7 for more information on the Free Look period.) The QI may elect to cancel enrollment in a QHP or QDP and select a different available QHP or QDP, as many times as he or she chooses within an enrollment period, as long as the QI completes submission of the cancellation request prior to his or her coverage effective date.

QHP and QDP issuers may initiate a cancellation transaction due to non-payment of the initial month's premium by the QI or qualified employer. CMS expects QHP and QDP issuers to transmit cancellation transactions to the FFM without undue delay and, when possible, prior to the coverage effective date. We realize that some enrollees will wait until just prior to their coverage effective date to make payment, and therefore issuers may receive payments the day prior to the enrollee's coverage effective date. Accordingly, issuers may not be able to determine which enrollments need to be cancelled prior to the beginning of a month. However, the FFM expects all cancellation transactions to be sent by QHP and QDP issuers by the third calendar day of what would have been the effective month of coverage.

Example 2I: In the FFM, a QI selects a QHP on November 2, 2013. The monthly premium is \$200 and the issuer does not make use of a premium payment threshold. The QI is eligible for a maximum APTC of \$75 per month. The QI selects the maximum APTC and therefore is responsible for a monthly premium payment of \$125. The FFM assigns the QI an effective date of January 1, 2014. The QI is therefore required to make payment of initial month's premium of \$125 to the QHP issuer no later than December 31, 2013. The QHP issuer does not receive any payment from the QI by December 31, 2013. The QHP issuer sends the FFM the 834 cancellation transaction on 1/2/2014. Therefore, the QHP issuer has met the FFM's expectation for timely transmission of the confirmation transaction.

Example 2J: Same circumstances as example 2I, except that the QHP issuer receives payment of \$125 on January 3, 2014. The QHP issuer should have already sent a cancellation transaction to the FFM. The QHP issuer should refund or return the payment to the QI.

In the FF-SHOPS, a qualified employer or a qualified employee must submit cancellation requests through the FF-SHOP. A qualified employer or qualified employee may choose to cancel coverage for any reason. For instance, an employer or employee may no longer want or need health insurance coverage through the FF-SHOP. A qualified employee must complete submission of his or her cancellation request to the FF-SHOP by 11:59 PM on the date prior to the coverage effective date.

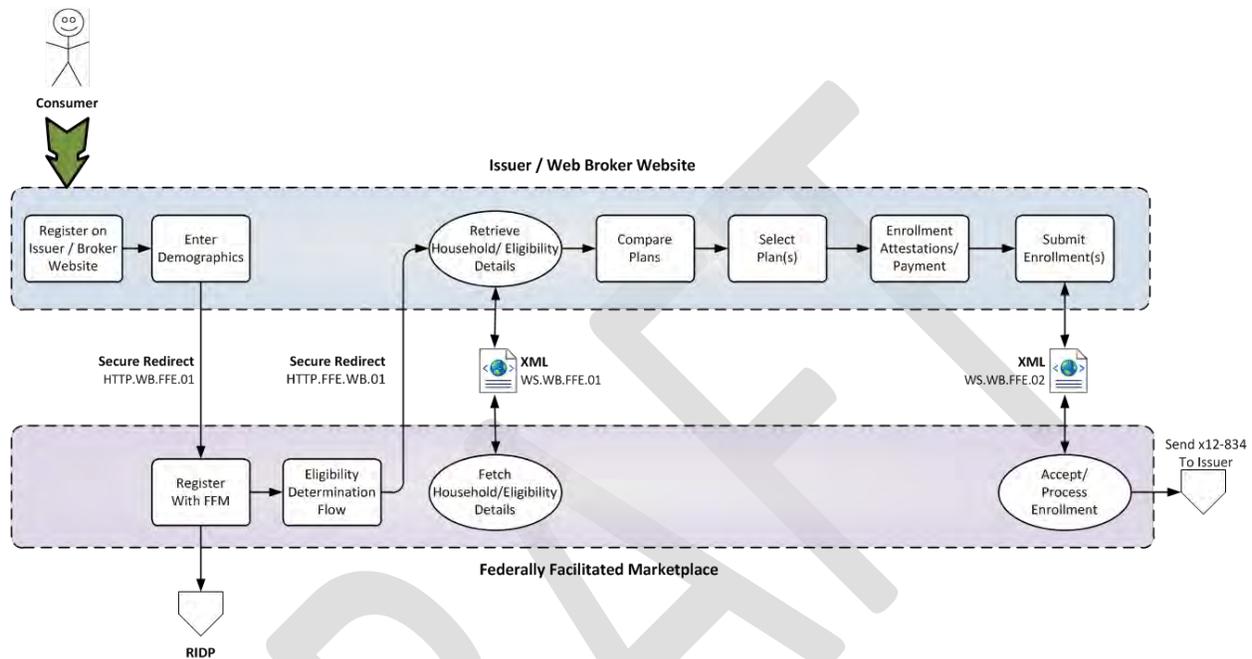
3.0 Direct Enrollment

3.1 Overview

The direct enrollment process allows an applicant to enroll in a QHP in a manner considered to be through the FFM when the process is originated through a QHP issuer website. The FFM has made available an application program interface (API) that allows a QHP issuer to submit enrollment requests to the FFM through a web service invocation. The enrollment requests are processed by the FFM and sent to the QHP issuer. The FFM direct enrollment API provides QHP issuer websites access to FFM eligibility and enrollment business services through a combination of secure transfers of the applicant to and from the FFM website and web services. The secure transfer of the applicant between the FFM and the QHP issuer website is used for submission of the eligibility application (for initial eligibility determinations as well as changes in circumstance). QHP issuers using the direct enrollment model should adhere to the same rules and policies that apply to all QHP issuer websites. Under this model, an applicant is redirected from the QHP issuer website to the FFM website to complete the eligibility

application. Upon receiving an eligibility determination, the applicant is transferred back to the QHP issuer website to continue plan shopping and selection. The plan shopping experience, including submission of the plan selection and amount of APTC selected (for those who are eligible), is implemented by the QHP issuer website using its own shopping and rating tools. Figure 3B below illustrates the process flow for an applicant shopping for QHPs through direct enrollment.

Figure 3B – New FFM Applicant



Additional Interactive Scenarios

For a comprehensive list of scenarios including returning FFM applicants, applicants found eligible for public programs such as Medicaid/CHIP, applicants wanting to report a change in circumstance, and the situations leading to disenrollment, please refer to, “FFM Direct Enrollment API for Web Brokers/Issuers Technical Specifications” located on CMS zONE, <https://zone.cms.gov/>. QHP issuers that wish to access CMS zONE may send their request to Calt_Support@cms.hhs.gov. This document provides a detailed sequential applicant flow and describes the interactions and responsibilities between the QHP issuer website and FFM for each scenario. It is updated frequently regarding changes to existing scenarios and the addition of new scenarios.

Guidelines for QI Experience in Certain Scenarios

The FFM provides eligibility results for all individuals seeking coverage on the application as part of the household/eligibility web services response. The FFM also provides information about whether each applicant is eligible for enrollment in a QHP through the FFM and, where the applicant has applied for insurance affordability programs. If applicable, the FFM will make a determination of eligibility for APTC and CSR and an assessment or determination of eligibility for Medicaid and CHIP, depending on the state's election. Furthermore, the FFM specifies what each applicant is not eligible for in the eligibility determination notice.

Applicant Not Eligible for QHP Enrollment

If an applicant is determined ineligible for enrollment in a QHP through the FFM, the information initially will be provided to the applicant on the FFM website. This information is retrieved by the QHP issuer as part of the household/eligibility web services response. The applicant is transferred back to the QHP issuer website, and the applicant can view and select a plan other than through the FFM, if desired.

Applicant is Eligible for QHP Enrollment and APTC/CSR

If an applicant is found eligible for enrollment in a QHP and APTC/CSRs, the FFM provides this information to the applicant on the FFM website, and the QHP issuer retrieves this information as part of the household/eligibility web services response. The FFM transfers the applicant back to the QHP issuer website to select a QHP. The QHP issuer must allow the QI to select the amount of APTC that they want to apply towards the reduction of their premium in the applicant's plan selection process and should only display the appropriate CSR plan variations for any of the QHP issuer's second lowest cost silver plans.

Applicant is Eligible for QHP Enrollment but *not* for APTC/CSR

If an applicant is found eligible for enrollment in a QHP but not APTC/CSRs, the FFM provides this information to the applicant on the FFM website, and the QHP issuer retrieves this information as part of the household/eligibility web services response. The FFM transfers the applicant back to the QHP issuer website to select a QHP. The QHP issuer should not include any APTC amounts for an applicant that is not eligible for APTC/CSR in the applicant's plan selection process and should not display any CSR plan variations.

Applicant is Eligible for Medicaid or CHIP

If an applicant is assessed or determined eligible for Medicaid or CHIP, the FFM sends an applicant's information to the appropriate Medicaid or CHIP agency and informs the applicant that the agency will follow-up with the relevant State agency regarding their enrollment status.

MAGI Scenario: If an applicant is determined eligible or assessed as potentially eligible for Medicaid/CHIP based on MAGI, their account is transferred to the state Medicaid/CHIP agency so the applicant will not be transferred back to the QHP issuer's website and the QHP issuer would not be able to place the applicant in an enrollment group. The QHP issuer would retrieve the eligibility information as part of the household/eligibility web services response.

If an applicant assessed as potentially eligible for Medicaid/CHIP is determined ineligible for Medicaid/CHIP by the state agency, the applicant is sent a notice from the FFM about his or her eligibility for QHP coverage. If an applicant receives an updated eligibility determination for eligibility to enroll in a QHP, including eligibility for any APTRC/CSRs, and comes through the QHP issuer's website, that updated information will be reflected in the household/eligibility web services response and the applicant can select a QHP from the QHP issuer.

Non-MAGI Scenario: The FFM will also screen applicants who request an eligibility determination for insurance affordability programs for eligibility for Medicaid based on factors other than MAGI (e.g., disability, long-term care needed). If an applicant indicates on his or her application that he or she is disabled or has a long-term care need, but he or she also has been determined eligible for enrollment in a QHP, the FFM will transfer the applicant to the QHP issuer website to select a QHP (if the applicant wants to select a QHP pending the outcome of the non-MAGI Medicaid eligibility determination), and the QHP issuer will retrieve the eligibility information as part of the household/eligibility web services response. If the applicant is eligible for APTC/CSR pending the outcome of the non-MAGI determination, the amount of APTC/CSRs available will be provided by the FFM as part of the household/eligibility web services response and should be used during the plan selection process. If a state subsequently notifies the FFM that the applicant was enrolled into Medicaid/CHIP, the FFM initiates the cancellation or termination of the enrollment.

Mixed Households

For households that include individuals eligible for different coverage programs (e.g., QHP with APTC, and Medicaid), QHP issuers should follow the guidelines outlined above for each applicant in the household. When an applicant is determined eligible or assessed as potentially eligible for Medicaid or CHIP based on MAGI, the FFM will transfer application information to the state Medicaid or CHIP agency, as applicable. QHP issuers should not include any applicants in the QHP selection process who are not listed as eligible for enrollment in a QHP in the information received through the household/eligibility web services response. Please note, however, that an applicant who is transferred to the Medicaid or CHIP agency may also be the household contact (and the individual who is conducting plan selection) for applicants in the household.

QHP issuers have the ability to create their own shopping experience once an applicant is directed to the QHP issuer's website. Nevertheless, if a household has applicants who are determined eligible for QHP enrollment and others who are not eligible for QHP enrollment through the Marketplace, the QHP issuer website must first complete the plan selection process for applicants eligible for QHP enrollment prior to completing the plan selection process for individuals who are not eligible for QHP enrollment through the Marketplace.

3.2 Enrollment Groups

Due to systems limitations, direct enrollment is currently limited to applicants enrolling in a single QHP from a single tax household. This means that it is only available to tax households filing one tax return and to issuers that offer QHPs; the FFM cannot support direct enrollment for QDPs at this time. If an applicant starts at a QHP issuer's website, completes the eligibility application on the FFM website, and

is identified as having multiple tax households, the FFM will not redirect the applicant back to the QHP issuer's website and the applicant will compare and select a plan on the FFM website.

If an applicant that is part of a single tax household is redirected to a QHP issuer website, the QHP issuer website should continue to use its current subscriber-dependent rules when determining who can be placed in a policy together. QHP issuer websites that are capable of supporting multiple enrollment groups must give applicants the ability to regroup into different enrollment groups, either combining into fewer enrollment groups if issuer relationship rules permit, or separating into more, valid enrollment groups, if desired. "FFM Direct Enrollment API for Web Brokers/Issuers Technical Specifications" addresses how to allocate APTC for multiple enrollment groups. If a QHP issuer website is unable to support multiple enrollment groups, it must make the applicant aware that he or she can access this functionality on the FFM website as described in the disclaimer below.

It is important to note that all QIs on a single application must enroll at the same time. Accordingly, QIs may enroll either through the FFM into one or more QHPs or through a single issuer utilizing direct enrollment. A QI cannot go to Issuer A's website and enroll some of the tax household and then go to Issuer B's website to enroll the remaining QIs. Additionally, since QIs need to select a medical QHP prior to selecting a QDP, dental issuers are not permitted at this time to participate in direct enrollment. Applicants that choose to enroll through the FFM may select a QDP after QHP selection. QHP issuers that do not offer dental must include this in the HHS-approved universal disclaimer described in section 3.3 below.

3.3 QHP Display Guidance

QHP issuers that plan to use direct enrollment must adhere to CMS requirements with respect to the display of QHP information. The QHP issuer website:

1. Must display or provide a link to the following information on its QHP pages for each QHP to the extent that the information is available as set forth in 45 CFR §156.1230(a)(1)(ii), acknowledging that some of this information may not be available for Year 1:
 - a. Standardized comparative information on each available QHP, including: (i) Premium and cost-sharing information (Total and net premium based on APTC and CSRs); (ii) Summary of benefits and coverage; (iii) Identification of whether the QHP is a bronze, silver, gold or platinum level plan or a catastrophic plan;
 - b. Provider directory;
 - c. The results of an enrollee satisfaction survey;
 - d. Quality ratings;
 - e. Medical loss ratio information; and
 - f. Transparency of coverage measures reported to CMS during certification.
2. Should not include the offering of non-QHP health plans or non-QHP ancillary products (i.e., vision, or accident) alongside QHPs. QHP issuers should provide applicants the ability to search for off-Marketplace products in a separate section of the QHP issuer's website other than the QHP Pages and such plans may be marketed and displayed after the QHP selection process has been completed. However, the QHP issuer website must clearly distinguish between QHPs for

which the QI is eligible and other non-QHPs that the issuer may offer, and indicate that APTC and CSRs apply only to QHPs offered through the FFM as set forth in 45 CFR §156.1230(a)(1)(iii).

3. Should provide filters for searching through plan options on QHP issuer's QHP web pages, which, may include, but are not limited to: (i) All plans; (ii) Premium; (iii) Deductible; (iv) Maximum out-of-pocket cost; (v) Plan type (e.g. HMO, PPO); (vi) Dental coverage included; and (vii) Health Savings Account eligible.
4. Must provide a way for applicants to select their APTC amount up to the maximum for which they are eligible as set forth in 45 CFR §156.1230(a)(1)(v), and subsequently update the net premium for the displayed QHPs. If an applicant is eligible for CSRs, but does not choose a silver level plan, the QHP issuer should inform the individual that they are eligible for CSRs if they choose a silver level plan.
5. Should ensure that information on its QHP webpages is provided to applicants in plain language and in a manner that is accessible and timely to individuals living with disabilities at no cost to applicants.

QHP issuer websites must ensure that the premiums charged to an applicant are the same as the amount the FFM would have calculated had the applicant selected a QHP via the FFM. It is important to note that the QHP issuer is responsible for collecting information on the tobacco status for each applicant and should factor that when calculating each QI's rate (the rating occurs after program and APTC/CSR eligibility). Currently, the FFM is only able to support changes in enrollees' tobacco status during open enrollment or a special enrollment period as part of the enrollment XML file provided from issuers to the FFM.

QHP issuers must provide an HHS-approved disclaimer as set forth in 45 CFR §156.1230(a)(1)(iv). QHP issuers must make this disclaimer available to all applicants regardless of how applicants communicate with the QHP issuer (such as through a website, by phone, in-person, etc.). We expect that issuers will make this available at the beginning of the plan comparison process and if an applicant is using an issuer's website, the issuer must prominently display this disclaimer when displaying plans to the applicant. The disclaimer must read:

"Attention: This website is operated by [Name of Company] and is not the Health Insurance Marketplace website. This website **does not** display all Qualified Health Plans available through the Health Insurance Marketplace website. To see all available Qualified Health Plan options, go to the Health Insurance Marketplace website at <https://www.healthcare.gov>.

Also, you should visit the Health Insurance Marketplace website at <https://www.healthcare.gov> if:

1. You want to select a catastrophic health plan.
2. You want to enroll members of your household in separate Qualified Health Plans.

[The plans offered here do not offer pediatric dental coverage and you want to choose a Qualified Health Plan that covers pediatric dental services or a separate dental plan with pediatric coverage.]*Certain pieces of the disclaimer, indicated in brackets, are not required but CMS encourages, a QHP issuer that does not offer these services to display those pieces of the disclaimer.

The QHP issuer should observe the following rules for displaying the disclaimer:

- Display the disclaimer prominently so it is noticeable to the applicant in the context of the website. The QHP issuer may change the font color, size or graphic context of the disclaimer to accomplish this. For example, the QHP issuer may use font in a color that clearly contrasts with the background of the webpage to draw attention to this disclaimer.
- Present the disclaimer in a font size no smaller than the majority of the text that appears on that particular page.
- Display the disclaimer in the same non-English language (such as Spanish) for any language that the QHP Issuer maintains screens for on its website.

3.4 Collection of APTC Attestations and Mandatory Attestation Language

QHP issuers using their websites to enroll individuals into QHPs in a manner considered to be through the FFM will collect attestations for those households receiving APTC as set forth in 45 CFR §156.1230(a)(1)(v). In the XML file that the FFM sends to QHP issuers related to eligibility, the FFM, based on the information provided in the application, identifies the expected tax filers for the coverage year from each tax household from whom the QHP issuer must collect an attestation. QHP issuers should have a box for the tax filer(s) signature(s), and validate that the names entered in the box match the names that were passed by the FFM.

For each household identified as needing an attestation, the QHP issuer should use the following language:

“Premium tax credit attestations

Review the statements below for [tax filer(s) – household 1]

I understand that because the premium tax credit will be paid on my behalf to reduce the cost of health coverage for myself and/or my dependents:

- I must file a federal income tax return in [coverage year +1] for the tax year [coverage year].
- If I’m married at the end of [coverage year], I must file a joint income tax return with my spouse.

I also expect that:

- No one else will be able to claim me as a dependent on their [coverage year] federal income tax return.
- I’ll claim a personal exemption deduction on my [coverage year] federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through this Marketplace and whose premium for coverage is paid in whole or in part by advance payments.

If any of the above changes, I understand that it may impact my ability to get the premium tax credit.

I also understand that when I file my [coverage year] federal income tax return, the Internal Revenue Service (IRS) will compare the income on my tax return with the income on my application. I understand that if the income on my tax return is lower than the amount of expected household income on my

application, I may be eligible to get an additional premium tax credit amount. On the other hand, if the income on my tax return is higher than the amount of income on my application, I may owe additional federal income tax.”

[Click “Agree” or “Disagree”]

Tax filer’s signature(s)

[Name of Tax Filer(s)] Upon sending the enrollment transaction to the FFM, QHP issuers indicate the amount of APTC the household has selected and confirms that the tax filer has attested to the language above. Additionally, the QHP issuer is expected to maintain attestations for up to ten years.

4.0 Federally-Facilitated Marketplace Special Enrollment Periods and Reporting Mid-Year Changes

Per 45 CFR §155.420, Special Enrollment Periods (SEPs) constitute periods outside the initial or annual open enrollment when a QI may enroll in a QHP and QDP or a QI can elect to change a current QHP and QDP selection as a result of a triggering event, such as birth/adoption, relocation, death, or loss of MEC.

It is the responsibility of the FFMs to determine whether a QI meets eligibility requirements for a SEP. The FFMs determine eligibility for SEPs, which are described by regulation at 45 CFR §155.420(d). In the individual market FFMs, Special Enrollment Periods generally last 60 days from the triggering event, per 45 CFR §155.420(c). In SHOPs, including FF-SHOPs, Special Enrollment Periods generally last 30 days from the triggering event, although there are two exceptions, when an enrollee loses Medicaid or CHIP coverage and when an enrollee becomes eligible for Medicaid or CHIP coverage. For the Medicaid and CHIP exceptions the SEP is 60 days. The start date of an SEP is based on the date of the triggering event. Although certain SEPs adhere to the standard effective dates described earlier in section 1.2, there are exceptions to this rule. For example, for birth, adoption, placement for adoption, or placement in foster care, coverage is retroactive to the date of birth, adoption, placement for adoption, or placement in foster care. For marriage and loss of minimum essential coverage (MEC), coverage is effective the first day of the month following plan selection.

Table 4F – Individual Market Special Enrollment Period Effective Date Examples

The SEP ends when the QI elects a QHP or when the SEP timeframe concludes. The Enrollment Period start dates below indicate the earliest date an individual could select a plan.

Triggering Event	Triggering Event Date	Date of Eligibility Determination by Marketplace	Enrollment Period Start Date	Enrollment Period End Date	Plan Selection Date Examples	Enrollment Effective Dates (first available date depending on the plan selection date)
Relocation	4/1	4/8	4/8	5/30	4/15	5/1
Relocation	4/10	4/10	4/10	6/9	4/16	6/1
Birth	6/1	7/20	7/20	7/30	7/29	6/1
Birth	8/25	9/12	9/12	10/24	9/15	8/25
Birth	12/26	1/9	1/9	2/24	1/13	12/26
Loss of Minimum Essential Coverage	4/28	4/28	4/28	6/27	4/29	5/1
Loss of Minimum Essential Coverage	4/15	4/20	4/20	6/14	5/2	6/1
Loss of Minimum Essential Coverage	5/12	5/23	5/23	7/11	6/12	7/1
Marriage	4/12	5/28	5/28	6/11	5/28	6/1
Gaining Lawful Presence	7/6	8/15	8/15	9/5	8/15	9/1

Table 4G – FF-SHOP Special Enrollment Period Effective Date Examples

The SEP for the employee ends when the individual elects a new QHP or when the SEP timeframe concludes. Enrollment Period start dates below indicate the earliest date an employee could select a plan.

Triggering Event	Triggering Event Date	Eligibility Determination Date	Enrollment Period Start Date	Enrollment Period End Date	Plan Selection Date Examples	Enrollment Effective Dates (first available date depending on the plan selection date)
Relocation	4/1	4/8	4/1	5/1	4/15	4/1
Relocation	4/10	4/10	4/10	5/10	4/16	5/1
Relocation	3/20	4/1	3/20	4/19	4/16	4/1
Birth	6/1	6/20	6/1	7/1	6/29	6/1
Birth	8/25	9/12	8/25	9/24	9/15	8/25
Birth	12/26	1/9	12/26	1/25	1/13	12/26
Loss of Minimum Essential Coverage	4/28	4/28	4/28	5/28	4/29	5/1
Loss of Minimum Essential Coverage	4/15	4/20	4/15	5/15	5/2	5/1
Loss of Minimum Essential Coverage	5/12	5/23	5/12	6/11	6/7	6/1

Reporting Changes

In accordance with 45 CFR § 155.330(b), enrollees and taxpayers are required to report changes to information on their application no later than 30 days after the change happens. These changes can be reported to the FFM via internet, phone, mail, or in person.

If changes are not reported, the enrollee or taxpayer could have potential liability to repay some or all of the APTC received during the year. Examples of changes that should be reported include:

- Relocation
- Household income changes
- Household size changes. For example, someone in this household marries or divorces, becomes pregnant, or has a child
- Becoming qualified for other health coverage (such as through an employer or Medicare)
- Changes in immigration status
- Becoming incarcerated, other than pending the disposition of charges

Some of these changes result in an SEP and enrollees can also report changes during the annual eligibility redetermination. During the annual eligibility redetermination, the FFMs will send out a notice

as stated in 45 CFR §155.335(c). This notice will include the projected eligibility determination for the following year. The enrollee has 30 days from the date of the notice to respond with any corrections to the eligibility information used in the redetermination, or eligibility for the following coverage year will be as stated in the eligibility redetermination notice.

For FF-SHOP, if information included in a qualified employee's application changes during the year, the employee may report the change. Examples of changes include 1) change of dependent status, and 2) change of eligibility for coverage by the employer based on job status.

5.0 Terminations

A termination is either a voluntary or involuntary cessation of coverage in a QHP that occurs after the enrollee's coverage effective date. The QHP issuer or the FFM can initiate involuntary termination of an individual's enrollment in the FFM. The effective date of a termination can be prospective; for example, an enrollee can voluntarily request termination because he/she is starting a new job in the near future that provides other minimum essential coverage. Termination can also be retroactive, such as in the case of death or failure to pay premium before the end of a grace period.

Termination of any enrollee may lead to either redetermination of the eligibility of the enrollment group or termination of the entire enrollment group. See 45 CFR §155.430 for detailed rules regarding termination of coverage.

The circumstances under which QHP issuers may initiate a termination of coverage in the FFMs are contained in 45 CFR §155.430(b)(2) and include terminations for: fraud, non-payment of premium, and loss of eligibility for coverage in a QHP through the FFMs.

Terminations for Fraud - § 147.128 Rules Regarding Rescissions

A QHP issuer may terminate an enrollee if he/she knowingly performs an act, intentional misrepresentation, practice, or omission that constitutes fraud defined by state-specific rules. For example, if a QHP or QDP determines that an enrollee willingly gave their QHP-issued ID card to another person so that person may obtain medical and/or dental services, the QHP or QDP may terminate the enrollee's coverage.

The effective date of the termination may be retroactive if allowed by state law. Further, if state law allows, the QHP issuer may deny medical or dental claims not yet received but incurred after the retroactive effective date of termination and reverse any paid medical or dental claims incurred after the retroactive effective date of termination. The QHP issuer must return any premiums paid by the enrollee for the period after the retroactive effective date of termination, and CMS will recoup any APTC paid for that period as well.

In accordance with 45 CFR §156.270(b), the QHP issuer must provide the enrollee with proper notice of the termination.

An FFM may also terminate an enrollee when the FFM has determined that the enrollee has committed fraudulent activity in the course of doing business with the FFM.

Terminations for Non-Payment of Premiums

Rules regarding termination for non-payment of premium can be found at 45 CFR 155.430 and 45 CFR 156.270. Issuers must establish and administer a standard policy for the termination of coverage for enrollees who fail to make full payment (or payment within the premium payment threshold if the issuer utilizes such) of their portion of the monthly premium. 45 CFR §156.270(d) requires issuers to observe a three-month grace period before terminating coverage for those enrollees who are ‘receiving’ APTC who have paid at least one month of premium in full (or paid within the premium payment threshold if the issuer utilizes such). An enrollee who is eligible for APTC but elects not to receive any APTC is not eligible for the three-month grace period but is eligible for the grace period the issuer normally provides to individuals who become delinquent in paying their premiums. An enrollee receiving APTC may enroll in both a QHP and a QDP. If the enrollee’s APTC is applied and paid on only the QHP, the enrollee is not eligible for the three-month grace period for the QDP. If APTC is applied and paid for both a QHP and QDP, the enrollee is eligible for the three-month grace period for both the QHP and QDP.

For enrollees receiving APTC and who are within the three consecutive month grace period, issuers may pend claims for services rendered during the second and third months of the grace period, if permitted by state law. If the enrollee is enrolled in both a QHP and a QDP, is receiving APTC for both plans, and is in the grace period for both forms of coverage, then both the QHP and QDP issuers may pend claims, if permitted by state law. If the enrollee fails to pay the premium before the end of the grace period, the issuer may then deny any claims that were pended during the second and third months of the grace period. However, the issuer cannot retroactively deny claims from the first month of the grace period. Any premium collected by the issuer beyond the designated retroactive termination date, should be refunded to the enrollee.

To avoid termination, enrollees must pay in full the portion of the premium for which they are responsible prior to the end of the applicable grace period. Grace periods do not “reset” when partial payments are made. For those issuers who make use of a premium payment threshold, once an enrollee fails to make payment within the threshold tolerance and is placed within the applicable grace period, the payment threshold does not apply, and the enrollee must pay all past due premium amounts before the end of the applicable grace period to avoid termination for non-payment of premiums.

In accordance with 45 CFR §156.270(d)(3), QHP and QDP issuers must notify providers of the possibility for denied claims for services incurred during months two and three of the grace period for enrollees receiving APTC. CMS’ expectation is that issuers will provide this notice within the first month of the grace period and throughout months two and three. Issuers can opt to provide this notice by several means, however, issuers are encouraged to provide this notice whenever responding to an eligibility verification request from a health or dental care provider.

Appendix C includes an example of the content an issuer might consider including in a letter to help inform development of a notice of non-payment of premiums. The specific wording and messages included here are not required, but are included as recommendations for elements to include in the plan’s notice of non-payment when an individual receives APTC.

Example 5A: An enrollee is eligible for but has elected not to receive APTC. The enrollee's monthly premium is \$200 and the issuer does not make use of a premium payment threshold. The enrollee has not paid the June premium, which was due on June 1st. The QHP issuer's standard policy, in accordance with state law, is to allow a one-month grace period for enrollees not receiving APTC. On June 10th the enrollee pays \$50 but does not make any further payment by the end of June. Therefore the QHP sends an 834 termination transaction to the FFM containing a termination effective date of June 30th.

Example 5B: An enrollee receiving APTC is responsible for a \$150 monthly premium payment and the issuer does not make use of a premium payment threshold. The enrollee pays his premiums through May but fails to make payment for his June premium, and therefore enters the three- consecutive month grace period that will run through August 31st. The enrollee fails to make any payment for the July premium, and now owes the QHP issuer \$300. On July 11, the enrollee pays \$200. However, since the enrollee has not paid the entire outstanding premium for which he is responsible, the enrollee remains in the three-month grace period that started June 1st. The enrollee fails to make any further payments, and on August 31st, the QHP issuer sends an 834 termination transaction to the FFM containing a termination effective date of June 30th.

Example 5C: Same circumstances as example 5B, except that on July 11, the enrollee pays \$300. Since the enrollee has paid the entire outstanding premium for which she is responsible, the enrollee is no longer in the grace period. However, if the enrollee fails to make full payment for August on the payment due date, the enrollee will enter into a new three consecutive month grace period beginning August 1st.

An enrollee terminated for failure to pay premiums is not afforded an SEP for loss of minimum essential coverage. However, at some point after termination for non-payment, the QI may qualify for an SEP for other reasons. Additionally, the QI may enroll during the next annual open enrollment period. In either case, the QI may be eligible for enrollment in the same QHP from which he or she was previously terminated. If the QI selects the same QHP from which he or she was previously terminated, the QHP cannot terminate enrollment in the QHP in which the QI newly enrolled based on failure to pay for any previously owed and unpaid premium.

Enrollee Requested Terminations

Enrollees may voluntarily request termination through the FFM. The rules for effective dates for enrollee-requested terminations can be found in 45 CFR § 155.430(d). The Marketplace must permit an enrollee to terminate his or her coverage in a QHP, including as a result of the enrollee obtaining other minimum essential coverage, with appropriate notice to the Exchange or the QHP.

Aging-off Terminations

State rules vary regarding the maximum age limit for an adult child to be covered as a dependent under the medical and dental coverage of a subscriber. Section 2714 of the Public Health Service Act, implemented at 45 CFR §147.120, states that, a group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age. Some states have more generous rules that allow certain individuals to remain covered as dependents beyond age twenty-six if additional criteria are met. Examples include place of residence, student status, disabled veteran status, marital status, or financial dependence.

During the QHP application process for the 2014 benefit year, QHP issuers were asked to provide limited information regarding rules around age limits in the states in which they plan to offer QHPs; however, the information was limited to the maximum age of the adult child and whether the child must live with the subscriber. Therefore, the FFM do not have all necessary information relating to exceptions that are more generous.

In order to accurately process enrollees aging-off their current coverage, on the 15th of each month QHP issuers should send the FFM an electronic file containing the list of enrollees who will attain coverage age-limits in the next two calendar months based on state rules.

For example, on January 15th each QHP issuer sends a file to the FFM identifying enrollees who will age-off coverage during February and March.

Upon receipt of the electronic file, the FFM will initiate a termination notice to enrollees to include information about how to select a new QHP. Subsequently, the FFM will initiate an outbound 834 transaction to QHP issuers terminating the aging-off enrollee. The FFM will conduct a redetermination of the remaining enrollment group, and send an outbound 834 change transaction to QHP issuers based on the redetermination, assuming the enrollment group is still eligible for coverage through the Marketplace, to include any changes in APTC and CSRs.

6.0 Retroactivity

Retroactive transactions could have either an enrollment or a termination outcome. Retroactive effective dates can result from unforeseen life events such as death, FFM or QHP error such as incorrect data being manually entered from a paper application, or from an administrative process, like an eligibility appeal decision. Effective dates of retroactivity can be located in: Terminations §155.430(d); Special Enrollment Periods §155.420(b); and Redeterminations §155.330(f).

- Reasons for Retroactive Enrollments and Effective Dates include but are not limited to:
 - Birth, Adoption, or Foster Care Date of Event
 - FFM or QHP/issuer Error – Original Effective Date
 - Exceptional Circumstances – Date to be determined by the FFM
 - Eligibility Appeals Outcome – (Under Development) Date determined by appeal outcome
- Reasons for Retroactive Terminations and Effective Dates include but are not limited to:
 - Death - Date of Event

- Fraud – Variable
- Exhausted 90-day Grace Period – Last Day of First Month of Grace Period
- Medicaid/CHIP – Day before the new coverage starts with Medicaid/CHIP
- FFM or QHP/issuer error – Original Effective Date
- Exceptional Circumstances – Date to be Determined by the FFM
- Eligibility Appeals Outcome – (Under Development)

Retroactivity Scenarios

Example 6A: An enrollee contacts the FFM on 04/25/2014 to inform the FFM of the birth of twins on 04/01/2014. The FFM does a redetermination of the enrollment group. The FFM sends an 834 change transaction to the selected QHP adding the newborn children with a coverage effective date 04/01/2014.

Example 6B: An enrollee contacts the FFM on 04/08/14 to report that his wife died 3 weeks earlier on 03/14/14. As a result of his wife’s death, the FFM representative informs the individual that he now qualifies for a SEP. The FFM confirms the date of death and sends the QHP issuer an 834 transaction with a termination effective date of 3/14/14. The widower decides to enroll through the FFM portal on 03/25/14. He decides to stay with same QHP issuer and will have an effective date of 04/01/14.

Example 6C: An enrollee receiving APTC fails to fully pay his or her portion of the monthly premium due for April coverage (or fails to pay within the premium threshold if the issuer utilizes such). The three month consecutive grace period commences 4/1/14. The enrollee fails to make any payments during the three months of the grace period. On 6/30/14, the QHP issuer sends the FFM an 834 termination transaction for non-payment with an effective date of termination of 04/30/2014.

7.0 Free-Look Provisions

Certain states have laws that provide an enrollee a “free look” at their chosen health and/or dental coverage. A free look provision allows an enrollee to retroactively cancel their coverage within the specified timeframe set by state law.

Because rules can vary by state, QHP issuers may initiate free look cancellation transactions as long as the request from the enrollee meets state specific time frames and any other applicable criteria. The cancellation date in the 834 transaction will be retroactive and must be the same as the first date of coverage. For example, if an enrollee’s coverage is effective January 1st, and the enrollee requests to cancel coverage under an available free look provision within the required timeframe, the cancellation date in the 834 transaction would be January 1st.

If an enrollee’s request to cancel coverage under a free look provision meets all required criteria, the QHP issuer must return any premium paid by the enrollee. Additionally, CMS will recoup any APTC paid to the QHP issuer for that enrollee.

*Operational feasibility is currently under development in conjunction with the Eligibility Support Workgroup [ESW] for year 1 operation.

Appendix A: Terms and Definitions

Applicant	As defined in 45 CFR §155.20
Application Filer: (Individual Application Filer or Primary Account Holder)	<ul style="list-style-type: none"> • As defined in 45 CFR §155.20 • The Marketplace Account user who is an adult who creates and submits an individual application from his or her My Account widget. Currently, there is no relationship restriction to the individuals being entered in the individual application that is created. • The My Account user who creates and submits the application is the primary account holder for the application that he or she submits. He or she has the ability to give another Marketplace Account User User(s) permission to make changes to exchange resources (i.e., granting Secondary Account Holders access for the primary account holder’s application). <ul style="list-style-type: none"> ○ List of permissions this person can give others <ul style="list-style-type: none"> ▪ Report changes in circumstances ▪ View plan changes ▪ View those referred to Medicaid /CHIP ▪ Terminate or cancel coverage • May be the person applying for themselves and/or others. Application Filer and Primary Account Holder are currently one and the same. • Example: In the case of a child only policy in which a father is applying for his two children, the ‘application filer’ would be the father and the ‘applicants’ would be the two children since they are the two people seeking coverage (the father is not). If the father was seeking coverage for himself and his two children, all three would be applicants to get coverage.
Advanced payment of the premium tax credit (APTC)	As defined in 45 CFR §155.20
Actual Advanced Premium Tax Credit (APTC)	The lesser of the maximum APTC or the premium of the plan selected at any level of coverage for the enrollment group. The actual APTC can then be further reduced by the individual and is the amount reported to the QHP issuer on the 834.
Benefit Year	In the FFM individual market a calendar year for which a health plan provides coverage for health benefits.
Cost-sharing reduction (CSR)	<ul style="list-style-type: none"> • Reduction in cost sharing for an eligible individual enrolled in a silver level plan in the Marketplace or for an individual who is an Indian enrolled in a QHP in the Marketplace. <p>OR</p> <ul style="list-style-type: none"> • As defined in 45 CFR §155.20, reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian enrolled in a QHP in the Exchange. Eligible individuals must be enrolled in one of five CSR plan variations in order to receive CSRs; in one of three silver plan variations, a limited cost sharing plan variation, or a zero cost sharing plan variation.
Enrollee	As defined in 45 CFR §155.20

Exchange Assigned Policy Identifier (ID)	The Exchange Assigned Policy Identifier (ID) is a number generated by the Exchange to represent the enrollment and to link together the members of the enrollment group. The Exchange Assigned Policy ID remains the same as long as the enrollment group is enrolled in the same qualified health plan (QHP) ID. A new Exchange Assigned Policy ID will be created when the enrollment group terminates enrollment with that QHP. No other change will require the Exchange Assigned Policy ID to change, i.e., number of qualified insured within the enrollment group, change to APTC amount applied to an enrollment group total premium, etc. This number will serve as the basis for CMS to appropriately identify and make APTC or CSR payments on behalf of that enrollment group.
Enrollment Group	All individuals enrolled and linked by the exchange assigned policy identifier. <i>Note:</i> Other individuals may be linked by the policy exchange identifier such as custodial parent, but may not be considered part of the enrollment group.
Federally Facilitated Marketplace (FFM)	As defined in 45 CFR §155.20
Household Contact	The Household Contact is the same as the Application Filer. The Household contact is the person (and his/her contact information) who can be contacted about the application which is completed.
Insured Member	An insured member is a person who has been enrolled for coverage under an insurance plan.
Maximum APTC	Maximum APTC is determined by the Exchange (through use of an IRS computation service) and is a factor of second lowest cost silver plan, household income, and the individual or family's Federal poverty level. This is the maximum amount of APTC an individual is eligible for when enrolled in a QHP at any level of coverage and is not reported on the 834.
Marketplace Account	Widget for self service on the FFM that allows My Account users to create an individual application, SHOP employee application, etc. My Account users do not need to be the policy holder for coverage purchased from applications they submit.
QHP Issuer	<ul style="list-style-type: none"> • A health insurance organization that can issue Qualified Health Plans (QHP) through a Marketplace. <p>OR</p> <ul style="list-style-type: none"> • A health insurance organization that offers a QHP in accordance with a certification from a Marketplace.
Qualified Individual (QI)	As defined in 45 CFR §155.20
Responsible Person	The responsible person is the person that is identified as the person(s) who are responsible for the Applicant Member. This person is not who is responsible for payment. An example of a responsible person could be case worker, executor of estate, power of attorney or legal representative.
MAGI	(Modified Adjusted Gross Income)-is used in Medicaid and CHIP to determine eligibility and has the same meaning as in 26 CFR §1.36B-1(e)(2) of the Internal Revenue code. Also used in the eligibility determination, as mentioned in 42 CFR 435.603(e).

Subscriber	<p>The subscriber is the person who has elected benefits or for whom benefits have been elected in the event that the application filer is not choosing health coverage. There is always only one subscriber per enrollment group and each member of the enrollment group will be associated with the subscriber. The subscriber may also be referred to as the anchor for the group.</p> <ul style="list-style-type: none"> • The FFE system will apply the following logic to identify the Subscriber: <ol style="list-style-type: none"> 1. The subscriber is the application filer AND is an insured member in the enrollment group. 2. If the enrollment group consists of children only, then the subscriber is the youngest child (to avoid the enrollment group dissolving when the oldest child ages off). 3. If neither of the two rules above applies, then the subscriber is the oldest insured member in the enrollment group
Tax Filer	<p>A tax filer is a person who will file taxes for the coverage year on behalf of a tax household and has allocated a portion of the tax household maximum advance payment of the premium tax credit amount toward the cost of the insurance policy.</p>

DRAFT

Appendix B: Sample Welcome Letter



Lisa Klein
[Insert address]

January 1, 2014

Dear Lisa,

Welcome to Birchwood Health Plan! This letter and package contain important information about your new health insurance coverage.

What's in this package?

- **Summary of Benefits and Coverage/Member Handbook** – A summary of your plan's coverage. It also includes information about your monthly premium and any out of pocket costs, like copayments, coinsurance, and deductibles.
- **Prescription Drug Benefits Formulary** – Provides information about medications we cover. You must use network pharmacies to obtain benefits, except under non-routine situations when you cannot reasonably use a network pharmacy.
- **Provider Directory**– Provides information on which providers are in our network. If you use a provider that is not in our network, your costs may be higher than if you use an in network provider.
- **Information about other coverage (If applicable)** – Provides information about additional coverage such as dental or vision coverage, and health club membership discounts.
- **Member ID Card** – You will be asked to present this each time you get care. *(Included if card is not mailed separately.)*

When does my coverage start?

The table below shows who is covered under the Birchwood Health Plan and the start date of coverage. Other members of your household not listed in this table are not covered under this policy.

Enrollee	Plan Name	First Day of Coverage
Lisa Klein	Birchwood Health Plan	January 1, 2014
Adam Klein	Birchwood Health Plan	January 1, 2014

Benefits may change from year to year. You will be notified of these changes before the annual open enrollment period, which is from October 15-December 7. You can change plans during the open enrollment period.



If Birchwood Health Plan stops offering coverage through the Marketplace for any reason in future years, you will receive a letter informing you that the plan is no longer available for renewal before the annual open enrollment period.

Where can I find additional resources?

You can contact us by phone at the numbers listed below, or you can visit our website at www.birchwoodhealthplan.com. Our website has many tools and resources available to you, including:

- Online account to view an explanation of benefits (EOBs) or make your premium payment
- Electronic copy of prescription drug benefits formulary
- Electronic provider directory
- Quick reference guide
- Notice of privacy policy

You may request paper copies of these documents by calling the Birchwood Health Plan help desk number listed below.

How can I contact Birchwood Health Plan?

If you have any questions or think this letter contains inaccurate information, you can call the Birchwood Health Plan helpdesk at 1-xxx-xxx-xxxx, Monday through Friday from 8am – 8pm EST, and Saturday and Sunday from 9am-5pm EST.

If you need advice about where and when to get care, you can call our nurse advice line 24 hours a day at 1-xxx-xxx-xxxx.

If you need help finding mental health or substance use disorder care, please call 1-xxx-xxx-xxxx Monday through Friday from 8am – 8pm EST, and Saturday and Sunday from 9am-5pm EST.

If you need information in another language, please call our language line at 1-xxx-xxx-xxxx.

Birchwood Health Plan
23 West Drive, Suite 300
Jacksonville, FL 32202

[Insert privacy disclosure language]

Appendix C: Sample Nonpayment Notice



Patrick Smith
[Insert address]

June 7, 2014

Dear Patrick:

Important information about your health coverage

This letter includes important information about your family's health insurance from Birchwood Health Plan. You may lose your health insurance coverage because you did not pay your monthly health insurance premium for June 2014 in the amount of \$155.00 by the due date, June 1, 2014. If you do not make your outstanding premium payment for June 2014 of \$155.00 by September 1, 2014 (as well as any additional premiums that become due between now and when you pay), you will lose your health insurance coverage from Birchwood Health Plan. Currently, your unpaid amount is \$155.00. If you wait until September 1, 2014 to pay, all your premiums for June, July, August, and September will be due on that day (\$620).

Because you are getting a tax credit to help pay for your insurance, you have a 3-month grace period to pay your outstanding premium before your insurance coverage will end. The 3-month grace period started on June 1, 2014 and will end on August 31, 2014. If you do not pay your June premium by August 31, 2014 (as well as any additional premiums that become due between now and when you pay), your enrollment in Birchwood Health Plan will be terminated, effective June 30, 2014.

What happens if I do not pay my premium?

If your coverage is terminated because you do not pay your full premium balance (including balances that become due for July and August) by September 1, 2014, your last day of coverage will be June 30, 2014. This means that you will be fully responsible for the cost of health services that you receive after June 30, 2014, if you do not pay your full premium balance by September 1, 2014.

What happens if my coverage ends?

If your coverage ends, you will be responsible for the cost of health services received after your last day of coverage (June 30, 2014), and you may not be able to enroll in another health insurance plan through the Marketplace until the next annual open enrollment period. Also, you may owe a penalty when you file your federal income tax return for the year if you have gaps in qualifying health coverage of three months or more during the year.

When will I be able to enroll in another health insurance plan if I am disenrolled?

You can apply for an eligibility determination to purchase a qualified health plan through the Marketplace during the next annual open enrollment period, from October 15-December 7, 2014.

If the information you included on your application to the Marketplace changes during the year, like your family size or circumstances (for example, if you marry, divorce, become pregnant, or have a child); your income; or if you move, you may qualify for a special enrollment period to enroll in coverage before the annual open enrollment period. You will need to tell Marketplace if you experience any changes, and they will tell you if you qualify for a special enrollment period because of the changes. To do this, log into your Marketplace account on HealthCare.gov/marketplace or call 1-800-318-2596 (TTY: 1-855-889-4325). Other events can qualify you for a special enrollment period, too. For more information, visit <https://www.HealthCare.gov>.

How do I make a payment?

To make a payment, visit Birchwood Health Plan’s website at www.birchwoodhealthplan.com, call member services, and select option 2 to make a payment, or send a check with your account number written on it to:

Birchwood Health Plan
23 West Drive, Suite 300
Jacksonville, FL 32202

If you already mailed your payment for the amount you owe, please disregard this notice.

What if I think this is a mistake?

If you think this information in this letter is a mistake, you need to tell Birchwood Insurance as soon as possible by calling the Birchwood Health Plan help desk at 1-xxx-xxx-xxxx, Monday through Friday from 8am – 8pm EST, and Saturday and Sunday from 9am-5pm EST.

Sincerely,

Birchwood Health Plan
23 West Drive, Suite 300
Jacksonville, FL 32202

[Insert privacy disclosure language]

Appendix D: Sample Termination Letter



Sam Allen
[Insert address]

April 22, 2014

Dear Sam,

Important: Your health insurance coverage is ending

This letter includes important information about your family’s health insurance from Birchwood Health Plan. Sam Allen and Linda Allen will no longer have health insurance coverage from Birchwood Health Plan on May 31, 2014 because you requested to terminate your insurance. You requested to terminate your insurance by calling our help desk on April 20, 2014.

The table below shows whose health insurance coverage will be terminated, the last day of coverage and why the insurance is ending. Any other members of your household not listed in this letter will not be affected.

Enrollee	Plan Name	Last Day of Coverage	Reason for disenrollment
Sam Allen	Birchwood Health Plan	May 31, 2014	Requested to cancel coverage
Linda Allen	Birchwood Health Plan	May 31, 2014	Requested to cancel coverage

What happens when my coverage ends?

If you terminate your coverage and do not get other health coverage, you will be fully responsible for the cost of health services that you receive after you are disenrolled from your plan. You may not be able to enroll in another health insurance plan through the Marketplace until the next annual open enrollment period, which is from October 15 to December 7, 2014. Also, you may owe a penalty when you file your federal income tax return for the year if you have a gap in health coverage of three months or more during the year.

When will I be able to enroll in another health insurance plan?

You can apply for an eligibility determination to purchase a qualified health plan through the Health Insurance Marketplace at <https://www.HealthCare.gov> during the next annual open enrollment period, from October 15-December 7.

If the information you included on your application to the Marketplace changes during the year, like your family size or circumstances (for example, if you marry, divorce, become pregnant, or have a child); your income; or if you move, you may qualify for a special enrollment period to enroll in coverage before the annual open enrollment period. You need to tell the Health Insurance Marketplace if you



experience any changes, and they will tell you if you qualify for a special enrollment period because of the changes. To do this, log into your Marketplace account on [HealthCare.gov/marketplace](https://www.HealthCare.gov) or call 1-800-318-2596 (TTY: 1-855-889-4325). For more information, visit <https://www.HealthCare.gov>.

What if I think this is a mistake?

If you think the information included in this letter is a mistake and you did not request termination of coverage, you need to tell Birchwood Insurance right away by calling the Birchwood Health Plan helpdesk at 1-xxx-xxx-xxxx, Monday through Friday from 8am – 8pm EST, and Saturday and Sunday from 9am-5pm EST.

Sincerely,

Birchwood Health Plan
23 West Drive, Suite 300
Jacksonville, FL 32202

[Insert privacy disclosure language]

ⁱ The Enrollment policy and guidance is not targeted for the State-based Marketplaces, however guidance will be forthcoming on reconciliation that will be relevant.