Federally-facilitated Marketplace and Federally-facilitated Small Business Health Options Program Enrollment Manual

This manual will go into effect as of October 1, 2015. All enrollments made on or after October 1, 2015, should be processed in accordance with the operational requirements set forth in this document. CMS intends to update this regularly, and publish clarifying bulletins between updates. All previous versions of bulletins that have been incorporated into this version of the manual should be considered superseded by this manual. If you have questions related to content posted within this manual, please email: EnrollmentGuidance@cms.hhs.gov.

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1. INTRODUCTION AND SCOPE

1.1 BACKGROUND

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this guide, the two statutes are referred to collectively as the Affordable Care Act (ACA). The ACA creates new competitive private Health Insurance Exchanges, known as Marketplaces, that enable qualified individuals (QIs) to shop for, select, and enroll in high quality, affordable private health plans. The Marketplaces also allow individuals to obtain an eligibility determination or eligibility assessment for coverage under Medicaid and/or the Children's Health Insurance Program (CHIP). In addition, the ACA created Small Business Health Options Program (SHOP) Marketplaces that enable qualified employers to provide health plans to their employees. QIs and qualified employers have been able to obtain coverage from private health insurance companies through the Marketplaces since January 1, 2014.[1]

1.2 TYPES OF MARKETPLACES

The Marketplaces established by the ACA take on several different forms, including:

- **State-based Marketplaces (SBMs):** SBMs exist in states that elected to operate their own Marketplaces.
- **State-based Small Business Health Options Programs (SB-SHOPs):** SB-SHOPs are types of SBMs through which qualified employers facilitate enrollment in qualified health plans (QHPs) offered through the small group market.
- **State-based Marketplaces – Federal Platform (SBMs-FP):** SBMs-FP rely on the federal eligibility and enrollment platforms used for the Federally-facilitated Marketplaces (FFMs) and/or FF-SHOPs. In these situations, a state is required to provide entry points for Medicaid/CHIP consumers (by phone, website, and paper application), as well as Medicaid customer support (through these means and the Marketplace call center).
- **FFMs:** Pursuant to Section 1321(c)(1) of the ACA, FFMs are operated by the federal government in states that did not elect to operate SBMs, or that the Secretary of the Department of Health & Human Services (the Secretary) determined would not have an operable Marketplace for the 2014 coverage year.

[1] For background information, see Section 1311(b)(1) of the ACA and 45 CFR §155.410(c)(i).

- **Federally-facilitated Small Business Health Options Programs (FF-SHOPs)**: FF-SHOPs are types of FFMs through which qualified employers facilitate enrollment in QHPs offered through the small group market.
- **State Partnership Marketplaces (SPMs):** SPMs are FFMs operated by the federal government in states that did not elect to operate SBMs, or that the Secretary determined would not have an operable Marketplace for the 2014 coverage year. However, in an SPM, the state is actively engaged with the federal government in the operation of certain aspects of the Marketplaces.

1.3 PURPOSE OF DOCUMENT

This document provides operational policy and guidance on key topics related to eligibility and enrollment activities within FFMs and FF-SHOPs, as well as within individual market Marketplaces and SHOPs that rely on the federal FFMs' or FF-SHOPs' eligibility and enrollment platforms (the SBM-FPs). For ease of reference, this document will use the terms "FFMs" and "FF-SHOPs" to refer to all individual market Marketplaces and SHOPs that rely on the federal eligibility and enrollment platforms, including SBM-FPs.

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

The information provided in this document applies to organizations and entities that may be involved in enrolling a QI or SHOP enrollee into a QHP or QDP using the FFMs' or FF-SHOPs' eligibility and enrollment functions. These entities include:

- Individual market Marketplaces relying on the federal eligibility and enrollment platforms
- SHOPs relying on the federal eligibility and enrollment platforms
- QHP and QDP issuers
- Agents and brokers (A/B) who are registered with the FFMs
- Assisters, counselors, and caseworkers
- Third-party administrators (TPAs) of QHPs, QDPs, or employer-sponsored coverage
- Trading partners of QHP and QDP issuers, such as health care clearinghouses.

1.4 ACRONYMS AND DEFINITIONS

Exhibit 1 and the subsection that follows describe the commonly used acronyms and terms that appear throughout this document.

1.4.1 Acronyms

Exhibit 1 – Commonly Used Acronyms

Acronyms	Descriptions
ACA	Affordable Care Act
API	Application Programming Interface
APTCs	Advanced Premium Tax Credits
A/B	Agent and/or Broker
BHP	Basic Health Program
BUU	Batch Utility Update
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
CIC	Change in Circumstance
CSRs	Cost-sharing Reductions
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EHB	Essential Health Benefits
EIN	Employer identification number
ER&R	Enrollment Resolution and Reconciliation
FFMs	Federally-facilitated Marketplaces
FF-SHOPs	Federally-facilitated Small Business Health Options Programs
FPL	Federal Poverty Level
HHS	Department of Health & Human Services
HICS	Health Insurance Casework System
HIPAA	Health Insurance Portability and Accountability Act
IRS	Internal Revenue Service
LC	Life Change
MAGI	Modified Adjusted Gross Income
MEC	Minimum Essential Coverage
MLR	Medical Loss Ration
MOEN	Marketplace Open Enrollment Notice
OEP	Open Enrollment Period
QDP	Qualified Dental Plan

Acronyms	Descriptions
PMP/PP	Partial Month Premium/Premium Proration
PTC	Premium Tax Credit
QHP	Qualified Health Plan
QI	Qualified Individual
RA	Risk Adjustment
RC	Risk Corridors
SBMs	State-based Marketplaces
SBMs-FP	State-based Marketplaces – Federal Platform
SBM-SHOPs	State-based Small Business Health Options Programs
SEP	Special Enrollment Period
TPA	Third-party Administrator

1.4.2 Definitions

Advanced Premium Tax Credits: Advanced Premium Tax Credits (APTCs), also known as advance payments of the Premium Tax Credit (PTC), can be used by eligible individuals who are enrolled in a QHP through an individual market Marketplace to lower their monthly premium costs. Eligible individuals may choose how much APTC to apply to their premiums each month, up to a maximum amount, which is then paid directly to the insurer. The APTC must be reconciled with the Premium Tax Credit on an individual's federal income tax return. If the APTC amount received for the year is less than the Premium Tax Credit, the individual will receive the difference as a higher refund or lower tax due. If the APTC amount received for the year is more than the Premium Tax Credit, the excess advance payments may have to be repaid with the individual's tax return.

Agent or Broker: Agent or Broker has the meaning set forth in 45 CFR §155.20.

Applicant: Applicant has the meaning set forth in 45 CFR §155.20.

Application Filer: Application filer has the meaning set forth in 45 CFR §155.20.

Auto Reenrollment (Passive): Auto reenrollment, also known as an 834 Enrollment Transaction, continues coverage in the individual market Marketplaces for the new plan year for an enrollee who does not actively select a plan for the new plan year during the Open Enrollment Period (OEP) and where coverage is continued automatically without a lapse in coverage if timely premium payment is made.

Consolidated Omnibus Budget Reconciliation Act (COBRA): COBRA is federal legislation that amended the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act in 1986, to provide for continuation of group health coverage that

otherwise might be terminated. COBRA contains provisions giving certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is available only when coverage is lost due to certain specific events.

Cost-Sharing Reductions (CSRs): CSRs have the meaning set forth in 45 CFR §155.20.

Data Baselining: The Data Baselining process is the interim process that CMS implemented to reconcile the enrollment records between health insurance companies issuing QHPs or QDPs and the Marketplaces using the FFMs' eligibility and enrollment functions to ensure all records are accurate.

Data Matching Issue/Inconsistency: When an application filer provides information to the Marketplaces as a part of the application process and the information the individual provided does not match the information received by the Marketplaces from its trusted data sources, such as the Office of Personnel Management, Department of Homeland Security or Social Security Administration (SSA), a data matching issue/inconsistency results. The individual needs to resolve data matching issues related citizenship or immigration within 95 days, and all other data matching issues within 90 days. Otherwise, the individual's enrollment through the Marketplaces will be terminated and the individual's APTCs and CSRs may be terminated or adjusted, if applicable.

Electronic Data Interchange (EDI): EDI is an automated transfer of data in a specific format following specific data content rules between a Marketplace and a QHP or QDP issuer. EDI transactions are transferred electronically through HealthCare.gov or SBMs.

Enrollee: Enrollee has the meaning set forth in 45 CFR §155.20.

Enrollment Group (in the individual market FFMs): All individuals enrolled and linked by the Marketplace-assigned policy identifier. *Note:* Other individuals may be linked by the policy Marketplace identifier, such as a custodial parent, but may not be considered part of the enrollment group.

Full-time Employee: An employee who is employed, on average, at least 30 hours of service per week. This definition does not apply in SBMs (including those using the federal eligibility and enrollment platform) until plan years beginning on or after January 1, 2016. (26 U.S.C. §4980(h) and 45 CFR §155.20)

Health Insurance Casework System (HICS): The authorized and secure electronic system recognized and used by the FFMs to input, track, and monitor consumers' and enrollees' concerns, unresolved issues, complaints, and cases that are not able to be resolved by CMS. HICS is also the electronic system the FFMs use to appropriately assign unresolved cases and communicate effective date changes to issuers, when appropriate, for resolution.

Insurance Affordability Programs: APTCs and CSRs, as well as Medicaid, CHIP, and, where applicable, the Basic Health Program (BHP).

Life Change (LC): A circumstance that could affect an applicant's or enrollee's eligibility for enrollment through the Marketplace or for insurance affordability programs (e.g., birth, adoption, foster care, change in household income) LCs that are not reported to the applicable Marketplace could potentially lead to an enrollee or applicable taxpayer repaying all or some of the APTCs the individual received during the year.

Marketplace Account: The Marketplace account provides a consumer with a user name and password to create an individual application, SHOP employee application, etc. A Marketplace Account user does not need to be the policyholder for coverage purchased from applications submitted by the Marketplace Account user.

Minimum Essential Coverage (MEC): MEC is the type of coverage an individual needs to have to meet the individual shared responsibility requirement under the ACA. The requirement to have minimum essential coverage can be fulfilled by a number of different types of coverage outlined in section 5000A(f) of the Internal Revenue Code and in 45 CFR §156.602, such as individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE, and certain other types of coverage.

Modified Adjusted Gross Income (MAGI): MAGI is the figure used to determine eligibility for insurance affordability programs in the Marketplaces, and for Medicaid and CHIP. Generally, MAGI is an individual's adjusted gross income plus certain other income, including tax-exempt Social Security, interest, or foreign income, and without certain deductions allowed for adjusted gross income. (26 CFR §1.36B-1(e)(2) and 42 CFR §435.603)

Open Enrollment Period (OEP): The period each year during which a QI may enroll or change coverage in an individual market QHP through the Marketplaces. (45 CFR §155.20 and 147.104)

Partial Month Premium/Premium Proration: Occurs in the Marketplaces when an enrollee has periods of coverage that last less than a full month. In the FFMs and FF-SHOPs, the pro-rated monthly premium for partial coverage months is calculated based on the actual number of days that the applicable enrollee or enrollees has/have coverage. Specifically, the premium is prorated as follows: the full month premium for one month of the coverage is divided by the number of days in the month. The result of the calculation is multiplied by the number of days in which the enrollee had coverage during the partial coverage month.

Plan Year: Plan year has the meaning set forth in 45 CFR §155.20.

Qualified Health Plan (QHP): A health insurance plan that meets certain requirements and, on the basis of meeting those requirements, is certified to be sold through a Marketplace. A QHP must be certified by each Marketplace through which it is sold.

QHP Issuer: QHP issuer has the meaning set forth in 45 CFR §155.20.

Qualified Individual (QI): QI has the meaning set forth in 45 CFR §155.20.

Qualified Employee: Qualified employee has the meaning set forth in 45 CFR §155.20.

Qualified Employer: Qualified employer has the meaning set forth in 45 CFR §155.20.

Enrollment Reconciliation: The ongoing process used to ensure consistency of enrollment and financial data between issuers and the FFMs. Because CMS pays APTCs and advance CSRs to QHP issuers on the basis of the enrollment files, it is critical that all entities' enrollment data is reconciled. In addition, the enrollment data stored in the FFMs is used as the basis for annual generation of Form 1095-A tax data for consumers. Discrepancies can arise when an issuer accepts a change from an enrollee based on HICS instructions (i.e., a change that has not been reflected in the FFMs, but one that the reconciliation process identifies) and enters it directly into its system. Per regulation, issuers are required to reconcile enrollment information with the FFMs at least monthly.

Reinstatement: Reinstatement is the correction of an erroneous termination or cancellation action that results in the restoration of an enrollment with no break in coverage. (45 CFR §155.430(e)(3))

Reenrollment (Active): An 834 Enrollment Transaction that continues enrollment in coverage through the individual market Marketplace for an enrollee who actively returns to the Marketplace during the OEP to make a plan selection for the new plan year.

SHOP application filer: SHOP application filer has the meaning set forth at 45 CFR §155.700(b).

Small employer: Small employer has the meaning set forth in 45 CFR §155.20.

Special Enrollment Period (SEP): SEP has the meaning set forth in 45 CFR §155.20.

Subscriber: A subscriber is the individual enrolling in coverage who has elected benefits for an enrollment group or the person for whom benefits have been elected by the application filer in the event that the application filer is not the person enrolling in 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.

Tax Filer: A tax filer is an individual who will file taxes for the coverage year on behalf of a tax household.

Web-broker: A web-broker is an individual A/B, group of A/Bs, or company that provides a non-FFM website to assist consumers in the QHP selection and enrollment process as described in 45 CFR §155.220(c)(3). (45 CFR §155.220(c)(3)).

1.5 ADDITIONAL RESOURCES

Exhibit 2 lists contact information for additional resources referenced throughout this document.

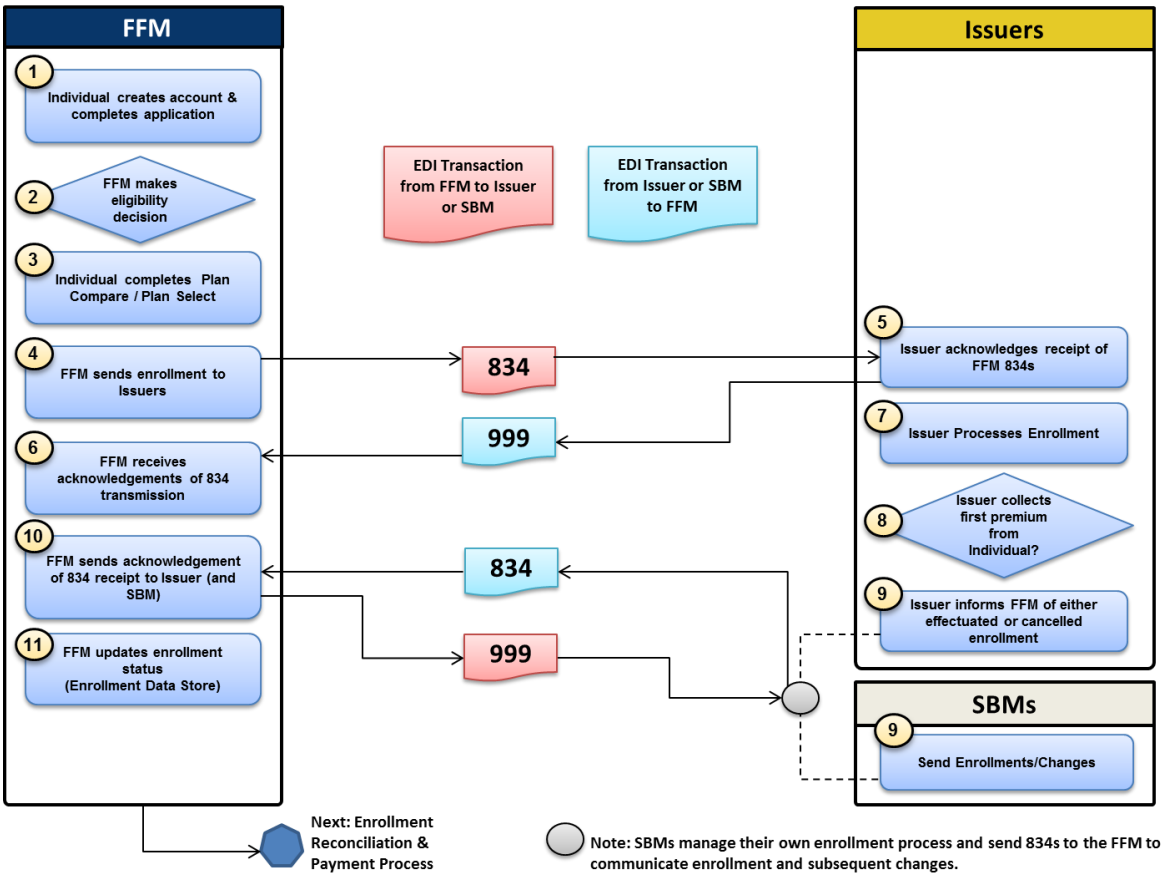
Exhibit 2 – Additional Resources

Resource	Contact Information
CCIIO	www.cms.gov/cciio
Marketplace Call Center	1-800-318-2596 1-855-889-4325 (TTY)
HealthCare.gov	www.healthcare.gov
Medicaid	www.medicaid.gov
Medicare	www.medicare.gov
REGTAP	www.regtap.info
FF-SHOP Call Center	1-800-706-7893 711 (TTY)
zONE	https://zone.cms.gov
Exchange Operations Support Center (XOSC) Help Desk	CMS_FEPS@cms.hhs.gov 855-CMS-1515

2. ENROLLMENT IN THE INDIVIDUAL MARKET FFMS (APPLICABLE TO FFMS/ QHPS/QDPS)

For QIs to purchase coverage in a QHP/QDP through FFMs, QIs must enroll in coverage through the FFMs during an OEP or qualify for an SEP (see Section 0, Special Enrollment Periods). Exhibit 3 depicts a high-level end-to-end system flow of the process for enrolling in a QHP/QDP through the FFMs. Please refer to Exhibit 3when reviewing the enrollment instructions in the succeeding sections.

Exhibit 3 – FFMs Enrollment Process



2.1 ELIGIBILITY

Pursuant to 45 CFR §155.405, an individual completes a single streamlined application for enrollment into coverage through the FFMs. The Marketplaces use this single streamlined application to determine both the individual's eligibility to purchase coverage through the Marketplaces and, if the applicant chooses to apply for insurance affordability programs, the individual's eligibility for APTCs, CSRs, and in some states, Medicaid and CHIP. Depending on

a state's election, the FFMs will either make final determinations of eligibility for Medicaid and CHIP based on the applicant's MAGI, or assess the applicant's 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 FFMs.

In all states, the FFMs will screen applicants for potential eligibility for Medicaid based on criteria other than MAGI, and will transfer applications 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. Medicaid and CHIP applicants always have the option to apply to their state Medicaid/CHIP agency directly.

If an individual is determined eligible to purchase coverage through the FFMs, the QI can compare available QHPs and QDPs, then select plans, as appropriate. If the QI applied for insurance affordability programs and has been determined eligible, the individual can select between $0 and the maximum amount of APTCs for which the individual is eligible. If the QI is determined eligible for CSRs, the QI will be shown plan variations that reflect the cost-sharing levels applicable to the individual. Once the QI selects a QHP/QDP, the FFMs provide enrollment information to the QHP/QDP issuer(s) electronically.

Consistent with the longstanding prohibitions on the sale and issuance of duplicate coverage to Medicare beneficiaries found in Section 1882(d) of the Social Security Act, it is illegal to sell or issue a QHP to a Medicare beneficiary with the knowledge that it duplicates Medicare benefits. This prohibition does not apply in the FF-SHOPs. CMS regularly provides information on Medicare and Marketplace coverage, posting frequently asked questions at: http://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html.

In addition, if an enrollee becomes eligible for Medicare after the individual has already enrolled in coverage through the Marketplaces, the enrollee may maintain coverage in the QHP. However, the enrollee loses eligibility for APTCs and CSRs. QHPs are encouraged to ask an enrollee who is newly eligible for Medicare whether the individual wishes to maintain coverage in a QHP and to provide instructions about how such an individual can report a change to the Marketplaces to terminate coverage or stop receipt of APTCs and CSRs to reduce the burden at tax filing.[2]

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[2] For more information on reporting LCs, see: https://www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/; https://www.healthcare.gov/what-if-i-have-a-marketplace-plan-but-will-be-eligible-for-medicare-soon/; and https://marketplace.cms.gov/technical-assistance-resources/report-life-event.pdf.

Individuals Who Are Determined Not to Be Qualified Individuals Due to Data Matching Issues

Applicants enrolled in individual market QHPs through the FFMs are notified if they need to submit documentation to the FFMs to verify information on their applications. Enrollees who do not submit sufficient documentation to the FFMs within the 90/95 day timeframe will have their eligibility determinations updated using the information contained in the trusted electronic data sources the Marketplaces use for verification. Issuers are encouraged to address consumer questions they receive directly, advising consumers of the importance of remitting requested materials timely.

In some cases, enrollees will not be able to be determined eligible for coverage through the Marketplaces based on information submitted by the enrollee or contained in trusted data sources, and will therefore be determined not to be QIs. These enrollees will lose eligibility for enrollment in a QHP through the Marketplaces. Such cases include when the verification sources cannot establish an enrollee's status as a U.S. citizen, national, or lawfully-present resident, and enrollees do not submit sufficient documentation of their citizenship, status as a U.S. national, or lawful presence.

When the FFMs cannot resolve a data matching issue, resulting in an enrollee being determined not to be a QI, the FFMs will send the QHP issuer an 834 termination transaction notifying the issuer of the FFMs' termination of the enrollee's Marketplace enrollment and termination of eligibility for APTCs and CSRs, if applicable. This termination will be effective on the last day of the month during which the FFMs determine that the individual is not a QI.

An individual who loses Marketplace coverage due to a data matching issue will be directed to the QHP issuer to pursue coverage outside the Marketplaces. The individual will not receive any APTCs or CSRs for any coverage outside the Marketplaces. The individual will generally be eligible for an SEP based on a loss of coverage or change in eligibility for APTCs and/or CSRs. The issuer is expected to work with the individual to avoid gaps in coverage and is encouraged to apply any amounts paid toward deductibles and out-of-pocket limits toward the individual's coverage outside the Marketplaces.

It is anticipated that, in most situations, the members of the enrollment group who remain eligible for coverage through the Marketplaces would constitute an enrollment group that can be accommodated by the existing Marketplace coverage. For example, if two parents and two children are in an enrollment group and one parent loses eligibility for coverage through the Marketplace, the remaining three family members could still constitute a valid enrollment group. If the remaining members of the enrollment group are still eligible for coverage through the FFMs, and for APTCs or CSRs, if applicable, they will be able to continue their Marketplace coverage and their APTCs or CSRs, if applicable.

Where the enrollee who is determined not to be a QI is the subscriber of the plan, the issuer is expected to apply any amounts previously paid toward deductibles and out-of-pocket limits toward the coverage of the remaining members of the enrollment group. Where the enrollee who

is determined not to be a QI is not the subscriber of the plan, and the QHP allows for removal of a dependent as an amendment to the policy, the issuer must apply any amounts previously paid toward deductibles and out-of-pocket limits toward the coverage of the remaining members of the enrollment group.

There may also be situations in which the removal of one or more members from an enrollment group will result in a remaining group of enrollees that does not constitute a valid enrollment group based on the issuer's business rules. For example, some issuers may not cover two children without an adult on a single family policy. The eligible members of the enrollment group remaining in the Marketplace will receive a 60-day SEP if the removal of an individual who was determined no longer eligible for coverage through the Marketplace results in the remaining members of the enrollment group being unable to reenroll into their same QHP through the Marketplace.

During the SEP, the Marketplace-eligible members of the enrollment group may select the same QHP (i.e., the same 14-digit QHP ID) through the FFM. If the Marketplace-eligible members enroll in the QHP under which they were previously covered, or select to enroll in the corresponding self-only QHP, or any combination thereof, then the QHP issuer is expected to apply any amounts previously paid toward deductibles and out-of-pocket limits to reflect the coverage as a continued enrollment. To prevent a gap in coverage, the enrollment group will receive an effective start date for the first of the month following the effective termination date specified in the 834 termination transaction. If necessary, the appropriate effective date of coverage will be communicated to issuers through HICS to prevent a gap in coverage.

Late Submission of Documentation for Data Matching Issues

Individuals whose Marketplace enrollment status and eligibility for APTCs and/or CSRs, if applicable, are terminated because they were determined not to be QIs due to their failure to submit sufficient data matching documentation will be provided an opportunity to reenroll in individual market coverage through the FFM outside of the OEP by producing sufficient documentation to resolve the data matching issue. In accordance with 45 CFR §155.420(d)(9), the FFMs will provide a 60-day SEP for an individual described above: (1) who submits the requested supporting documentation to the FFMs; (2) for whom the verification sources are able to establish information based on the trusted electronic data sources or using the sufficient documentation submitted to resolve the data matching issue; and (3) who is determined eligible for enrollment in a QHP through the Marketplaces.

Under the SEP, the individual will be able to select new individual market QHP coverage through the Marketplaces. The individual described above, who submits sufficient documentation to resolve the data matching issue, may request a retroactive effective date to avoid potential gaps in coverage. The retroactive effective date of Marketplace enrollment, and APTCs and CSRs, if applicable, will be the day after the effective date of the termination from previous coverage. Alternatively, under 45 CFR §155.420(b)(2)(iii), the individual may request a prospective effective date of Marketplace enrollment for the 1st of the month following plan

selection. The appropriate retroactive effective date of coverage will be communicated to issuers through HICS, if necessary.

If, under the SEP, the individual selects the same coverage through the FFM under which the individual was previously covered through the FFM, the issuer is expected to apply any amounts previously paid toward deductibles and out-of-pocket limits toward the coverage enrolled in under the SEP.

Individuals who have their eligibility updated due to certain data matching issues (for example, annual household income) may experience an adjustment to their eligibility for insurance affordability programs, but remain QIs. The QIs will continue to be enrolled in coverage through the Marketplaces with their updated eligibility determination applied. Such individuals may return to the Marketplaces to report a change in information to update their eligibility. The reported changes may result in an updated eligibility determination and may qualify the individual for an SEP to make coverage changes.

2.2 OPEN ENROLLMENT AND COVERAGE EFFECTIVE DATES

During the OEP, a QI may enroll in a QHP. The QI can make multiple elections during the OEP. However, the last election made by the end of the OEP that is effectuated will be the coverage in which the QI is enrolled through the FFMs. If the QI enrolled in a QHP and paid the binder payment, as required by 45 CFR §155.400(e), but then selected another QHP during the OEP and that enrollment is effectuated for the same coverage effective date, the issuer of the previous QHP will need to cancel the coverage and refund premiums. The issuer of the previous QHP will receive notification of the plan selection change from the Marketplaces. Outstanding enrollments will also be identified during enrollment reconciliation.

Coverage effective dates are based on a QI's QHP selection date and begin as early as January 1. QIs who qualify for an SEP during the OEP may receive a coverage effective date as indicated in Section 0, Special Enrollment Periods. Under 45 CFR §155.310(c), the FFMs 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 an SEP for FFM coverage, or for Medicaid or CHIP, for which there are generally no restrictions on when an individual can enroll.

Exhibit 4 illustrates coverage effective dates for the 2016 OEP.

Exhibit 4 – Coverage Effective Dates for the 2016 FFMs OEP

Plan Selection Date	Coverage Effective Date
November 1, 2015, through December 15, 2015	January 1, 2016
December 16, 2015, through December 31, 2015	February 1, 2016
January 1, 2016, through January 15, 2016	February 1, 2016
January 16, 2016, through January 31, 2016	March 1, 2016

2.3 ENROLLMENT TRANSACTIONS

Federal regulation (45 CFR §155.270) requires all Marketplaces to use standards, implementation specifications, operating rules, and code sets adopted by HHS under HIPAA and the ACA when conducting certain electronic transactions with a covered entity, such as a QHP issuer. Additionally, HHS oversees and monitors the FFMs' issuers and non-Exchange entities to verify compliance with security and privacy standards, as required by 45 CFR §155.280.

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

CMS released a Standard Companion Guide Transaction Information (Companion Guide)[3] to explain how certain new data elements, such as APTCs and CSRs data in the FFMs, and employer and qualified employee premium contributions in the FF-SHOPs, will be included in the existing version of the 834 enrollment transaction. Issuers offering QHPs or QDPs through the FFMs or FF-SHOPs must use the 834 enrollment transaction in combination with the updated Companion Guide for purposes of enrollment transactions.

On rare occasions (e.g., natural disasters, serious technical problems), it may be necessary to transmit an enrollment file in a non-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 and validation rules to protect the privacy of enrollee information, which must be restrictive as transactions are applied in an automated, near "real-time" manner to the FFMs and FF-SHOPs.

Enrollment transactions in the FF-SHOPs consist of two independent transactions between an FF-SHOP and QHP or QDP issuers (group enrollment transactions and 834 enrollment transactions). Employer Group Enrollment is the transaction through which the FF-SHOPs will transmit detailed information to issuers regarding the employer offering group coverage through the FF-SHOPs. Since 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 on 834 enrollment transactions, can be found in the Companion Guide.

For purposes of transmitting enrollment information to QHP and QDP issuers, the FFMs and FF-SHOPs will transmit daily (limited to business days for FF-SHOPs) electronic files to the issuers

[3] Available at http://www.cms.gov/cciio/

or their trading partners in the adopted 834 enrollment transaction. 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 Companion Guide.

Initial Enrollment Transaction

In the FFMs, once a QI selects a QHP, and QDP if desired, the FFM sends an 834 enrollment transaction to the issuer. The FFM will accumulate transactions and send them once each day (seven 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 based on the timestamp and EDI file. Additionally, any inbound 834 transaction updates the FFMs by passing strict automated rules.

2.4 APPLICATION AND ENROLLMENT CHANGES

In accordance with 45 CFR §155.330(b), and as specified in 45 CFR §155.305, 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 FFMs via internet or by calling the Marketplaces.

Some LCs reported by the enrollee may result in changes to an enrollee's eligibility for coverage or financial assistance through the FFMs, or may qualify the enrollee for an SEP. If changes are not reported, the enrollee or taxpayer may be liable to repay some or all of the APTCs received during the year.

Issuers should instruct enrollees to follow the process for reporting changes through the FFMs provided in Exhibit 5.

Exhibit 5 – Process for Reporting Changes

Step	Process
1	The consumer logs in to his or her account and presses the "Report a Life Change" button (this button is enabled only for consumers who have already submitted an application).
2	The consumer will land on a page with information about the types of changes that must be reported to the Marketplace or both the Marketplace and the issuer.
3	If the consumer has changes to report that may affect eligibility, a new copy of his or her application is created, pre-populating some information and attestations from his or her earlier application.

Step	Process
4	The consumer completes the new application and answers questions which determine whether the applicants for whom new information is being provided are eligible for QHP or QDP enrollment through the FFMs, and if so, whether the new information triggers an SEP.
5	If the consumer is eligible for an SEP, the consumer's eligibility determination notice will contain SEP eligibility language.
6	If any applicants for whom new information is being provided are eligible to enroll in a QHP/QDP through a Marketplace (i.e., they are QIs), the QI will proceed to the enrollment to-do list page.
6a	If the applicant for whom new information is being provided is a QI and their addition to coverage is based on an event that triggers an SEP, the QI will have the ability to compare and select from all QHPs and QDPs available to the applicants in the service area.
6b	If the new information being provided does not trigger an SEP, the QI will be limited to updating their enrollment information in the QHP or QDP in which they are currently enrolled.
7	The QI eligible for an SEP will select a new plan (or the existing plan, depending on the situation) and set the amount of APTCs the tax household will use.
8	Once the QI eligible for an SEP selects a plan, or the QI not eligible for an SEP completes his or her enrollment information, the system will generate an 834 termination transaction to the issuer with whom the individual was initially enrolled, and an 834 enrollment transaction will be sent to the gaining issuer (in cases where the QI updates their existing enrollment, the enrollment transaction will go to the same issuer and should be treated as a modification, rather than a new enrollment).

Exhibit 6 provides a list of reportable changes. Enrollees can also report changes during the annual eligibility redetermination. For more information on the redetermination process, see Section 2.9, Redeterminations and Renewals.

Exhibit 6 – Reportable Changes

Type of Change	Where to Report
Increase or decrease in projected annual household income for 2016 or change to current month's household income	FFM
Add or remove applicant or non-applicant household member listed on application	FFM
Relocation to a new ZIP Code or county	FFM
Gain or loss of other health coverage	FFM

Type of Change	Where to Report
Pregnancy that would affect eligibility for Medicaid under applicable state rules	FFM
Change in tax filing status (will or won't file, joint or separate filer) or change in tax dependents that will be claimed	FFM
Newly incarcerated or released from incarceration	FFM
Change in immigration status or citizenship	FFM
Change in status as member of federally recognized tribe	FFM
Became disabled or in need of long term care (or is no longer in need of care)	FFM
Change to available employer coverage	FFM
Correct/update the relationships between family members	FFM

2.5 PREMIUM PAYMENT IN INDIVIDUAL MARKET FFMS

Payment Redirect

For the initial enrollment with an issuer, once a QI confirms plan selection at HealthCare.gov, the FFMs will enable redirection of the QI from HealthCare.gov to the issuer's payment site if the issuer provided a payment site in its QHP application. If the QI selects plans from more than one issuer, then the FFMs will enable multiple payment redirects, with each redirect occurring in a separate window. Payment redirect will typically occur before the FFMs generate 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 a QI's plan selection and, if eligible, the APTCs amount selected. To address this, FFMs will electronically transfer basic information in the redirection to the issuer's payment portal so that the QHP issuer can accept payment. Information sent in the payment redirect, includes subscriber information, plan selection, the QI's portion of premium due, and the amount of APTCs applied to the premium.[4]

QHP issuers may, but are not required to, accept payment online. Enrollees similarly are not required to make online payments. CMS considers it a best practice for plans to accept payment immediately to expedite a confirmed enrollment. If a QHP issuer is not capable of accepting

[4] For a complete description of payment redirect, see SBS EXCH EE: 209 Payment Redirect to Issuer Payment Portal Business Service Definition, posted on REGTAP.

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 an active payment redirect link until the effective date of the plan. If a QI completes plan selection via the Marketplace Call Center, or in any case when the QI is not redirected online to the QHP issuer to make an initial premium payment (including where payment is made after the plan effective date but before the premium payment deadline established by issuer), the QI may contact the selected QHP issuer to arrange payment (typically by phone). As QIs may contact issuers by phone for premium payment or other premium issues, CMS expects QHP issuers' customer service staff to be equipped with telephonic scripts to handle such calls.

Once a QI has paid their 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 A – Sample Welcome Letter, includes an example of the content an issuer might consider including in the cover letter as part of the enrollment package.

Premium Payment Methods

QHP issuers are required to accept paper checks, cashier's checks, money orders, electronic fund transfers (EFTs), and all general-purpose prepaid debit cards[5] as methods of payment in the FFMs. Further, according to 45 CFR §156.1240(a)(2), the QHP issuer must present all payment method options equally for a QI to select the 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 improperly 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 their choice of valid payment method. For example, an issuer may not pass on administrative fees for processing a premium payment via credit card.

2.5.1 Premium Payment Due Date

QHP issuers in the FFMs may establish deadlines for payment of the first month's premium in connection with regular effective dates no earlier than the coverage effective date, but no later

[5] Including those issued by state agencies for the purpose of paying for benefits, including health care.

than 30 calendar days from the coverage effective date pursuant to 45 CFR §155.400(e)(1). In instances where issuers are processing enrollments with retroactive or other special effective dates, the due date for payment of the first month's premium must be 30 calendar days from the date the issuer receives the enrollment transaction. The issuer must receive full payment (or payment within the premium payment threshold in accordance with Section 6.1, Premium Payment Threshold, if the issuer utilizes such a threshold) from the enrollee for any applicable initial premium by the applicable premium payment deadline. Issuers may not grant grace periods for payment of the initial month's premium.

When issuers are adding retroactive coverage to an already effectuated enrollment, the enrollee must pay all outstanding retroactive premium by the later of: 1) the time period mandated by state rules, or 2) the issuer's stated due date. In the absence of more generous state regulations, CMS encourages issuers to allow at least one full billing cycle for enrollees to make such a payment of retroactive premium.

For the purpose of enrollment in a QHP, payment can be considered received when an EFT is completed, a credit or debit card transaction is processed, or a paper check or money order is in the issuer's possession (i.e., received and logged in the issuer's mailroom).

Under 45 CFR §156.1250, issuers offering individual market QHPs must accept premium and cost-sharing payments made on behalf of QHP enrollees by Indian tribes, tribal organizations, urban Indian organizations, and state and federal government programs or grantees, such as the Ryan White HIV/AIDS programs. If an enrollee notifies the QHP issuer of coordinated premium payment with one of the third party entities described in 45 CFR §156.1250, issuers should allow for timely premium payment to prevent termination of enrollments for non-payment. CMS may take enforcement action against QHP issuers that fail to comply with this requirement.

2.6 CONFIRMATION OF THE 834 TRANSACTION IN INDIVIDUAL MARKET FFMS

In the FFMs, once an issuer receives either full payment or payment within its established premium payment threshold in accordance with Section 6.1, Premium Payment Threshold, for any applicable initial premium due from the enrollee, and the issuer has received the initial 834 enrollment transaction, the issuer will send the FFM a full 834 effectuation/confirmation transaction (confirmation transaction). The confirmation transaction provides the FFMs verification that the issuer has effectuated enrollment.

Issuers should not wait to confirm enrollment of an individual until after the APTCs are 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 QI is responsible.

When a QI pays his or her portion of the first month's premium before the coverage effective date, CMS expects QHP and QDP issuers to send the confirmation transaction to the FFM by the fifth calendar day of the effective month of coverage. Where the first month's premium payment

is made after the effective date of coverage, and coverage is prospective from the plan selection date, but effectuated retroactively from the date that payment is made. CMS expects QHP and QDP issuers to send the confirmation transaction to the FFM without undue delay.

Examples

Example 2A*:* A QI selects a QHP on November 20, 2015, and is therefore assigned a coverage effective date of January 1, 2016. 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 issuer has established a premium payment deadline of the coverage effective date. The QI is, therefore, required to make payment of initial month's premium of $125 to the QHP issuer no later than January 1, 2016. The QHP issuer receives payment of $125 from the QI on December 31, 2015. The QHP issuer then sends the FFM the 834 confirmation transaction on January 2, 2016. The QHP issuer has met the FFM's expectation for timely transmission of the confirmation transaction.

Example 2B: Same circumstances as Example 2A, except the QI mails a payment of only $100, but does so on December 16, 2015 and the issuer uses the premium payment threshold method. The issuer receives the payment on December 18, 2015. The enrollee makes an additional payment towards the initial month's premium of $25 on December 21, 2015, and the issuer receives the payment on December 28, 2015. The QHP issuer then sends the FFM the 834 confirmation transaction on December 30, 2015. The QHP issuer has met the FFM's expectation for timely transmission of the confirmation transaction.

2.7 CANCELLATIONS IN INDIVIDUAL MARKET FFMS

Pursuant to 45 CFR §155.430(e)(2), a cancellation transaction is a specific type of termination that ends a QI's enrollment on the date coverage became effective resulting in coverage never having been effective with the QHP. Cancellations can be initiated by the issuer or the applicant. Cancellation transactions initiated by the QI are voluntary and must be submitted through the Marketplaces. A QI 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 they have gained other coverage. Or, the QI 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 must complete submission of their cancellation request to the FFM by 11:59 PM ET on the date prior to the coverage effective date. A QI who enrolled through the FFM cannot request a cancellation after his or her coverage effective date unless the enrollee is in a free look period. (See Section 2.8, Free Look Provisions). The QI may elect to cancel enrollment in a QHP or QDP and select a different available QHP or QDP, as many times as they choose within an enrollment period, as long as the QI completes submission of the cancellation request prior to their coverage effective date.

QHP and QDP issuers in the FFMs may initiate a cancellation transaction due to non-payment of the initial month's premium by the QI. CMS expects QHP and QDP issuers will transmit cancellation transactions to the FFMs without undue delay.

Examples

Example 2C: A QI selects a QHP on December 12, 2015, and, therefore, is assigned a coverage effective date of January 1, 2016. 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 issuer has established a premium payment deadline of 30 days from the coverage effective date. The enrollee mails the $175 payment on January 30, 2016. The issuer does not receive the payment until February, 3, 2016. The issuer should send the FFM an 834 cancellation transaction without undue delay, and refund the individual $175 since the payment was not received prior to the effective coverage date. Any APTCs paid on the behalf of the enrollee must be returned to the FFM.

Example 2D*:* Circumstances are the same as Example 2C except the enrollee mails a payment of $100, but does so on December 16, 2015, and the issuer has established a premium payment deadline of the effective date of coverage. The issuer receives the payment on December 18, 2015. 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 effectuated on January 1, 2016, and the issuer should send the FFM the 834 cancellation transaction without undue delay, and refund the individual $100. Any APTCs paid on the behalf of the enrollee must be returned to the FFM.

2.8 FREE LOOK PROVISIONS IN INDIVIDUAL MARKET FFMS (APPLICABLE TO QHPS/QDPS)

Certain states have laws that provide a qualifying enrollee in health insurance coverage a free look period.[6] These provisions allow an enrollee to retroactively cancel coverage in a QHP or QDP in the FFMs, within a certain period of time.

In states with laws providing for a free look period, an enrollee in an FFM may request cancellation from coverage in their QHP and QDP after their coverage effective date. As rules

[6] The FF-SHOP system is not able to accommodate free look provisions at this time.

can vary by state, QHP and QDP issuers may initiate free look cancellation as long as the request from the enrollee meets state-specific timeframes and any other applicable and established criteria.

Premium refund policy in the case of free look cancellations will follow existing state-specific guidelines. Generally, if an enrollee's request to cancel coverage under a free look provision meets all required criteria, the QHP or QDP issuer must return any premium paid by the enrollee. Additionally, CMS will recoup any APTCs paid to the QHP or QDP issuer for that enrollee. The issuer should report the cancellation to the FFM during the monthly enrollment data reconciliation.

If a QI cancels his or her QHP or QDP coverage pursuant to a free look period during OEP, the QI may select a new QHP or QDP. Cancellation under the free look period does not qualify for an SEP in the Marketplaces.

Examples

Example 2F: In an FFM, an enrollee residing in a state with a free look period selects a QHP on December 5, 2015, with a coverage effective date of January 1, 2016. The enrollee takes the necessary actions to qualify for a free look cancellation within 30 days of coverage from the start of coverage under state law. On January 30, the enrollee requests cancellation under the free look law from the enrollee's QHP issuer. The QHP issuer processes the request with a cancellation date of January 1, 2015.

The enrollee may return to the Marketplaces to select new coverage with a prospective effective date as long as the enrollee is still within the OEP.

Example 2G: In an FFM, an enrollee residing in a state with a free look period selects a QHP on January 5, 2016, with a coverage effective date of February 1, 2016. The enrollee takes the necessary actions to qualify for a free look cancellation within 30 days of coverage from the start of coverage under state law. On February 28, the enrollee requests cancellation under the free look provision from the enrollee's QHP issuer. The QHP issuer processes the request with a cancellation date of February 1, 2016.

To enroll in coverage through the FFM, the enrollee must wait until the next OEP or must qualify for an SEP as provided in 45 CFR §155.420.

2.9 REDETERMINATIONS AND RENEWALS IN INDIVIDUAL MARKET FFMS (ANNUAL OPEN ENROLLMENT)

Pursuant to 45 CFR §155.335, Marketplaces have the flexibility to conduct annual redeterminations using either the procedures described in 45 CFR §155.335 (b) through (m), alternative procedures specified by the Secretary for the applicable plan year, or alternative procedures approved by the Secretary based on a showing by the Marketplaces that such procedures meet specified criteria. The alternative procedures are described in detail below.

On August 25, 2015, CMS published guidance on the reenrollment process for the 2016 Health Insurance Marketplace coverage for issuers in FFMs, "Guidance for Issuers on 2016 Reenrollment in the Federally-facilitated Marketplace (FFM)," available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016AutoReenrollmentBulletin16.pdf. For the 2016 Plan Year, the FFMs will provide a Marketplace Open Enrollment Notice (MOEN) to all individuals currently enrolled in a QHP through the FFMs in advance of the OEP for 2016 coverage. This notice will contain certain basic information, including a description of the annual redetermination and renewal process, the requirement to report changes affecting eligibility and the channels for reporting such changes, and the last day a plan selection may be made for coverage starting January 1 of the upcoming plan year. For enrollees who authorized the FFMs to request updated tax return information for use in the annual redetermination process and who are receiving APTCs or income-based CSRs, this notice will have information on the APTCs reconciliation process.

MOENs will contain special messaging based on criteria that a QI may meet, see guidance published by CMS on April 22, 2015, available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/annual-redeterminations-for-coverage-42215.pdf. For QIs receiving APTCs or income-based CSRs, the FFMs may determine a family's income is above 500% of the federal poverty level (FPL) based on updated tax return information. If the family did not authorize the FFMs to check tax return information for the purpose of annual redetermination, or the family's authorization has expired, or the family received APTCs but did not file the required tax return, then the family is at risk for losing eligibility for APTCs and CSRs at the end of 2015. The family will be reenrolled in coverage in a QHP for 2016 without APTCs or CSRs to the extent that coverage can be renewed in accordance with 45 CFR §147.106, if the family takes no action to update their application information.

Additionally, the FFMs will provide targeted messaging to consumers who are enrolled in a QHP with APTCs or CSRs, who authorized the FFMs to request updated tax return information for use in the annual redetermination process, and who meet one of the following criteria: (1) no updated tax return information was provided by IRS; (2) the family's income is above 350% FPL in the most recent eligibility determination; (3) IRS provided family tax data that when evaluated with family size; (4) is above 350% FPL; (5) reflects an increase or decrease of greater than 50% of the family's income for the most recent 2015 eligibility determination; (6) is under 100% FPL; or (7) other criteria established by the FFMs. This notice will state the same information as the standard notice, along with an explanation that the FFMs strongly encourages enrollees receiving APTCs or CSRs to contact the FFMs to obtain an updated eligibility determination from the FFMs and make a plan selection by the last day of plan selection for a January 1 coverage effective date, as specified in 45 CFR §155.410(f).

For a QI who does not contact the FFM to obtain an updated eligibility determination and select a QHP by the last day on which a plan selection may be made for coverage effective January 1, 2016, in accordance with the effective dates specified at 45 CFR §155.410(f), the FFMs will

establish 2016 eligibility based on a hierarchy of the most recent data available. The FFMs may use IRS data or verified, updated consumer-provided application data associated with an enrollment, whichever is most recent, together with updated FPL tables and benchmark plan premium information to update eligibility for APTCs and CSRs.

Reenrollment for the next plan year can be either "active" or "passive." An active reenrollment is initiated by an enrollee returning to the FFMs during the OEP to submit an application and select a plan for the next plan year. It is important that current FFM enrollees who are seeking to actively reenroll access their HealthCare.gov accounts to update their eligibility information and make plan selections. This will provide enrollees with a pre-populated application, and will help the FFMs and issuers in maintaining the continuity of the enrollment. Tips for enrollees who have trouble logging into their HealthCare.gov account are available at: https://www.healthcare.gov/help/i-am-having-trouble-logging-in-to-my-marketplace-account/.

Passive reenrollment, also called auto-reenrollment or batch auto-reenrollment, is the process that the FFMs use to reenroll current enrollees who do not return to the FFMs to submit an application and select a plan by the last day of plan selection for a January 1 coverage effective date, as specified in 45 CFR §155.410(f). Issuers indicate next year's auto-reenrollment plan to the FFMs by indicating the reenrollment plan on the Plan ID Crosswalk Template in current year Plan ID/service area combinations. The Plan ID Crosswalk is submitted by the issuer with other plan materials during the QHP certification process. The FFMs use the Plan ID Crosswalk Template to conduct the passive reenrollments.

Reenrollment is the general term used to describe coverage continued into a new plan year, whether the next plan year's coverage is under the same or different "product" (as defined in 45 CFR §144.103). In this context, renewal specifically refers to reenrollments into the same product.

For the 2016 Plan Year, most passive reenrollments will be sent to issuers before the start of the OEP to provide issuers time to prepare issuer-provided reenrollment notices, which will include information about the APTCs that will be provided if the consumer is auto reenrolled. Enrollees who visit HealthCare.gov and check their HealthCare.gov account during the OEP will not see their passive reenrollment until December 16. Issuers should not communicate with consumers regarding these reenrollment transactions prior to the date which the QHP issuer would begin its regular billing cycle as described in the guidance published by CMS on April 22, 2015, available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/annual-redeterminations-for-coverage-42215.pdf.

For passive reenrollments, issuers must reenroll an enrollee in a QHP in accordance with the hierarchy described at 45 CFR §155.335(j). This generally requires that an enrollee be renewed in the same QHP, if available, or a plan in the same product, if available through the Marketplaces. Only if no plan in the same product is available through the Marketplaces may the issuer reenroll the enrollee into a different product available through the Marketplaces. If there is no renewal option available, the issuer may non-renew coverage for the enrollee with the requirements of the applicable exception under 45 CFR §147.106.

Any current plan year enrollee who would like to be enrolled in a different plan for the next plan year should return to the FFM and select the new plan by December 15, for the new plan's coverage to be effective beginning January 1 (unless the enrollee is also determined eligible for an accelerated or retroactive coverage effective date due to an SEP). A QI can make an election at any time during the OEP, even if a previous passive or active reenrollment has been effectuated.

Should the enrollee make an active plan selection before December 15, any passive reenrollment transaction previously sent by the FFMs should be disregarded. Similarly, enrollees can change their plan selection at any time during the OEP, even if their coverage has already been effectuated. The new coverage will start in accordance with normal effective dates, unless enrollees have an SEP that allows for non-standard effective dates.

Reenrollment Communications to Enrollees

In addition to the MEON, issuers are also required to send notices of product discontinuation and renewal to current enrollees as specified in 45 CFR §147.106 and 156.1255. In general, if the issuer is discontinuing the product, the issuer must send a discontinuation notice at least 90 calendar days before the date the coverage will be discontinued. However, in connection with the OEP for the 2016 Plan Year, CMS will not take enforcement action against an issuer that provides a discontinuation notice related to individual market coverage within fewer than 90 days, as long as the issuer provides such notice consistent with the timeframe applicable to renewal notices (which for non-grandfathered plans is before the first day of the next annual OEP). For more information on federal standard notices of product discontinuation and renewal in connection with the OEP for the 2016 Plan Year, see guidance published by CMS on July 7, 2015, available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-on-Notices-of-Product-Discontinuation-and-Renewal-for-the-2016-Coverage-Year.pdf.

The federal standard notices of product discontinuation and renewal and more information on the renewal process, is available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Renewal-Notices-9-3-14-FINAL.PDF.

Finally, if the enrollee has not returned to the Marketplaces to make an active selection for the next plan year by the cut-off date for a January 1 coverage effective date, the Marketplaces will send both an updated Eligibility Determination Notice and an Enrollment Confirmation Message to the enrollees informing them of the passive reenrollment. The Enrollment Confirmation Message will note whether the enrollees on the relevant application were successfully reenrolled. If the enrollees were reenrolled, the confirmation message indicates the plan name(s) and Plan ID(s), and information about any financial assistance that was applied. If not reenrolled (because the coverage was discontinued by the issuer, or the enrollees on the application are not eligible for passive reenrollment), consumers are encouraged to complete an application and plan selection through the FFM, and encouraged to contact the FFM to see if an SEP may be available for a coverage effective date of January 1, 2016.

2.9.1 Enrollment Transaction Types

Active reenrollments for the following calendar year's coverage are sent in daily batches as 834 initial enrollments to issuers according to current FFM procedures. Active reenrollment 834 transactions sent to issuers also include plan selection changes made within the new plan year, such as when an enrollee replaces 2016 Plan A with 2016 Plan B during the OEP. Plan selection changes are sent as a cancel/term transaction to the first plan, and an initial enrollment transaction to the gaining plan (plan selection changes are not sent as a Change in Circumstance [CIC]).

Regular CIC transactions where enrollees report a change to their application information for either current or next year's coverage during the OEP, such as updating income, reporting a new phone number, or adding a new family member, are sent according to existing procedures. CMS expects the FFMs to send passive reenrollment transactions in two waves, one beginning on or around October 15, 2015, for the majority of eligible enrollees, and the second wave beginning around December 16, 2015.

Passive reenrollments are initial enrollment transactions with a Maintenance Type Code (INS03) of 021 "Addition," and a Maintenance Reason Code (INS04) of 41 "Reenrollment." All passive reenrollments have an effective date of January 1, and will be sent with EFT Functional Code of I834AR.

2.9.2 834 Transactions for Redeterminations and Renewals

Active and passive reenrollments are sent as 834 initial enrollment transactions. The Marketplaces will send cancellations for the passive reenrollments of enrollees who complete an active plan selection after the passive reenrollment transaction has been sent but before the deadline for making a plan selection for coverage effective January 1. An initial enrollment will be sent to the issuer of the plan selected by the consumer through an active plan selection, which will include eligibility updates, if applicable. An issuer who receives a cancellation of the passive reenrollment should not renew the enrollment unless the enrollee has actively renewed coverage in the same plan, causing an active reenrollment transaction to be sent. For enrollees who have been passively reenrolled but then make a plan selection change after the cut-off for January coverage, the FFMs will terminate their passive reenrollment effective the day before the actively selected plan becomes effective. In no case does a plan selection for the upcoming plan year send a termination to the current year issuer for current year coverage.

For enrollees who actively reenroll for the next plan year before the Marketplaces send auto-reenrollment transactions for them, the Marketplace will not send a passive reenrollment transaction. If the enrollee actively enrolls with a different issuer for the next plan year, the Marketplaces will list the subscriber on an electronic file sent daily to the current issuer. This list of current year subscribers who have actively "switched" issuers for the next plan year is provided so that current year issuers can non-renew the listed enrollees' enrollments (see the "Switched File" section for additional information).

Identifiers on Enrollment Transactions:

- FFM-assigned Subscriber ID and Member ID, also known as Exchange Assigned Subscriber ID and Exchange Assigned Member ID, remain the same for enrollees choosing the same issuer (i.e., 5-digit HIOS ID) for the next plan year.
- FFM policy numbers are new for all next year plan selections, whether active or passive.
- FFMs will not send issuer-assigned identifiers on reenrollments.
- An A/B National Producer Number (NPN), if recorded on the current plan year enrollment, will be sent on passive reenrollments. For an active reenrollment, the NPN from the current year will be pre-populated on the next year application, but may be removed or edited by the applicant. NPN and other A/B information can be recorded on Plan Compare, not just the application. However, if an NPN is entered on Plan Compare during the plan selection process, that NPN will supersede any NPN that was entered in the eligibility application. Exhibit 7illustrates the rules governing the sending of NPNs.
- Information for assisters who are not A/Bs will not be sent on passive reenrollments.
- Assister information for all types (e.g., Navigators, Certified Application Counselors,) will be sent on active reenrollments according to existing procedures.

Exhibit 7 – NPN Rules Illustrated

NPN Scenarios	NPN on Current Year Enrollment	NPN Sent on 1000c Loop on Next Year 834 Enrollment Transaction
Auto-reenrolled (passive) consumer	123	123
Active reenrollment by returning consumer who updates the next year application, and is able to view and edit the current year A/B, but doesn't change or remove the A/B associated with his or her application	456	456 (The A/B info from the current year application will be pre-populated on the next year application)
Active reenrollment by returning consumer who removes the A/B information on his or her next year application	789	None. A consumer can remove the A/B info on the next year application.

Exhibit 8 illustrates reenrollment transaction scenarios and their associated 834 maintenance reason code, FFM subscriber ID and whether effectuation is sent to the FFM.

Exhibit 8 – Reenrollment Transaction Illustration

Scenario	834 Maintenance Reason Code	FFM Subscriber ID (next year vs current year)	Send Effectuation to FFM?
Auto-reenrollment (passive) – A current enrollee does not return to the FFM to update eligibility and plan selection. His or her coverage is renewed by the issuer as indicated on the Plan ID Crosswalk Template.	INSO4: 41	Same	If enrolled in the same product – No; If enrolled in a different product – Yes
Active reenrollment – A current enrollee returns to the FFM by December 15 to actively apply and enroll in next year coverage. The enrollee's next year selection is the same product as is the current year. The enrollee's passive reenrollment is cancelled by the FFM when it sends the initial enrollment.	INSO4: EC	Same	No
Active switch after auto-enrollment – A current enrollee actively applies at the FFM and enrolls with a different issuer by December 15. The enrollee's passive reenrollment is cancelled by the FFM. Since the enrollee switched to a different issuer, the enrollee will also appear on Switch File[7], so the current year issuer will non-renew the enrollee's coverage.	INSO4: EC	New	Yes

[7] The Switch File is an electronic file delivered separately for each issuer offering plans through FFMs to identify the issuer's current subscribers who have actively reenrolled in ("switched") next year coverage offered by a different issuer.

Scenario	834 Maintenance Reason Code	FFM Subscriber ID (next year vs current year)	Send Effectuation to FFM?
Active switch before auto-reenrollment – A current enrollee actively enrolls with a different issuer on November 1, before the enrollee was passively reenrolled. The FFM will not send a passive reenrollment because the enrollee is already actively enrolled, thus there is no passive reenrollment for the FFM to cancel. However, the enrollee will appear on the Switch File, so the current year issuer will non-renew his or her coverage.	INSO4: EC	New	Yes
Blended (passive, then active CIC) – A current enrollee is passively reenrolled effective January 1. Because the enrollee was in the special notice group and failed to update his eligibility information, he is enrolled with zero APTCs. On December 18, the enrollee actively returns to report updated eligibility information via a CIC and is determined eligible for APTCs, reselecting the same plan, with the updated information taking effect February 1. The FFM sends the passive reenrollment effective January 1, then a January 31 term/ February 1 initial CIC reflecting the update.	January 1 initial (no APTCs): INSO4: 41 February 1 CIC initial (with APTCs) INSO4: EC	Same Same	No No

Exhibit 9 illustrates multiples transactions for a single enrollment where the same enrollee visits HealthCare.gov on three separate occasions.

Exhibit 9 – Multiple Transactions Illustrated for a Single Enrollment

Transaction Date	December 16	December 18	January 2
Description	Passive reenrollment sent	Consumer changes plans	Consumer reports a life change
Key 834 codes	Origin Type on 834 =11 (auto-reenroll) INSO4 MRC = 41	Origin Type on 834=1 (FFM Online) INSO4 MRC = EC Straight term/initial (not CIC)	Origin Type on 834 = 1 (FFM Online) INS04 MRC = EC CIC syntax
EDI Functional Code	I834AR	I834	CIC834

For detailed transaction requirements, issuers should continue to consult the Companion Guide instructions related to the ASC X12 Benefit Enrollment and Maintenance 834 Transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the FFM.

2.9.3 CSRs & APTCs Calculations on Passive Reenrollments

For enrollees who authorized the Marketplaces to request updated tax return information on their behalf for use in the annual redetermination process and who do not contact the Marketplaces to obtain an updated eligibility determination and select a QHP by the last day on which a plan selection may be made for coverage effective January 1, 2016, the Marketplaces will establish 2016 eligibility as follows:

- First, where an enrollee was in the special notice group, opt-out group, or did not reconcile group, the Marketplaces will discontinue APTCs and income-based CSRs.
- Second, where an enrollee with APTCs or income-based CSRs does not fall into the special notice group, opt-out group, or did not reconcile group, the Marketplaces will use the current year family size and the most recent income and other eligibility information available, updated FPL tables, and updated benchmark plan premium information to calculate APTCs and determine eligibility for income-based CSRs for the next plan year.

Enrollees who actively return to the Marketplace to submit updated eligibility information for next year coverage will have their eligibility redetermined according to standard processes, with updated eligibility taking effect according to the effective dates described in 45 CFR §155.410(f).

2.9.4 Plan Selection Changes During the OEP

During an OEP or SEP, an enrollee may change plans, even if the original selection's coverage (active or passive) has been effectuated. Effective dates for enrollee changes to plan selection post-effectuation will align with normal effective dates as established in 45 CFR §155.410(f) (although in some cases an SEP with accelerated or retroactive effective dates may apply). An enrollee can change plans by contacting the Marketplace Call Center or by logging into his or her HealthCare.gov Account, accessing "My Plans and Programs," and selecting "Change Plan." Enrollees may change plans during a valid enrollment period without reporting a life change on their application. All plan selections that replace another selection are considered active enrollments. If the new selection has the same effective date as of the original selection, the original selection is cancelled. If the new selection has an effective date after the original selection has started, the original selection will terminate on the day before the new selection takes effect in order to facilitate continuous coverage for the enrollee.

2.9.5 Enrollee Switched List

When an enrollee whose policy is in current (not cancelled or terminated) status completes an active reenrollment for next year coverage in a plan offered by a different issuer from the current

year issuer, the FFM will not send the current year issuer an 834 termination transaction. Rather, for enrollees for whom the FFM has already sent passive reenrollments, the current year issuer will receive a cancellation for the next year passive enrollment. However, for enrollees who actively switch issuers between plan years and for whom no passive enrollment has been sent, there is no passive reenrollment to cancel.

To address this, the FFM will produce an electronic file for each issuer offering plans through the FFM that identifies the issuer's current subscribers who have actively reenrolled in ("switched") to next year coverage offered by a different issuer. This file will be generated daily during the run-up to the cut-off for January coverage. Each Enrollee Switched List will be cumulative, identifying current enrollees who have switched issuers as of their most recent plan selection on the day before the file is generated. Note that current year issuers will find the current year subscriber both cancelled and listed on the Enrollee Switched List, if the enrollee switched issuers after the FFM auto-reenrolled them; current year issuers will have only the Enrollee Switched List to determine if a subscriber's enrollment should be non-renewed if the FFM had not sent a passive reenrollment as of the issuer switch.

Each Switch File will be cumulative, identifying current enrollees who have switched issuers as of their most recent plan selection on the day before the file is generated. If an enrollee who has switched issuers for next year subsequently switches back to a plan offered by the enrollee's current year issuer, that enrollee will be removed from the next daily Switch File. A QDP subscriber will appear on the Switch File if the current subscriber either actively enrolled in a QHP without a QDP for the next plan year, or if the QDP subscriber actively switched to a different QDP issuer.

Note that the Switch File excludes subscribers who were auto-reenrolled and later switch to a different issuer, since the current year issuer will have the cancelled passive reenrollment transaction as the indicator that the enrollment is to be non-renewed. Enrollees who actively enroll in any next year plan offered by the same current year issuer will also not be included on the Switch File because the issuer will be aware of the plan change via the active enrollment transaction.

2.9.6 Effectuation at Reenrollment and Change in Circumstance

Issuers will not need to send the FFM an effectuation transaction for any subscriber passively or actively renewing coverage (into the same product with the same issuer), who will have the same FFM-assigned Subscriber ID for both plan years. Similarly, issuers need not send effectuations when an enrollee selects the same product in an enrollment update reported through a CIC. Note that issuers must continue to send effectuation transactions for reenrollments into a different product, even though the FFM-assigned ID may be the same. Effectuation transactions are also required for enrollments with a new subscriber, such as a young adult child being reenrolled as a new subscriber in a passive reenrollment age-off scenario. Issuers must also send effectuation transactions for active enrollments for new enrollees and for returning enrollees who did not have continuous coverage with the issuer.

2.9.7 Life Changes During the OEP

An enrollee will be able to report life changes triggering CIC transactions to issuers for both current year and next year coverage during the OEP. Changes to current year coverage, such as the addition of a baby or spouse, will be reflected on the passive reenrollment for next year coverage if reported to the FFM by December 15. After December 15, changes to current year coverage cannot be initiated by the enrollee in self-service mode on HealthCare.gov, but must instead be made through the Marketplace Call Center, which can also assist enrollees in updating their applications and coverage for the next year, if necessary.

Enrollees who have actively selected next year coverage by December 15, and subsequently want to update their current year coverage based on a CIC should take care when contacting the Marketplace Call Center to update their next year coverage as well.

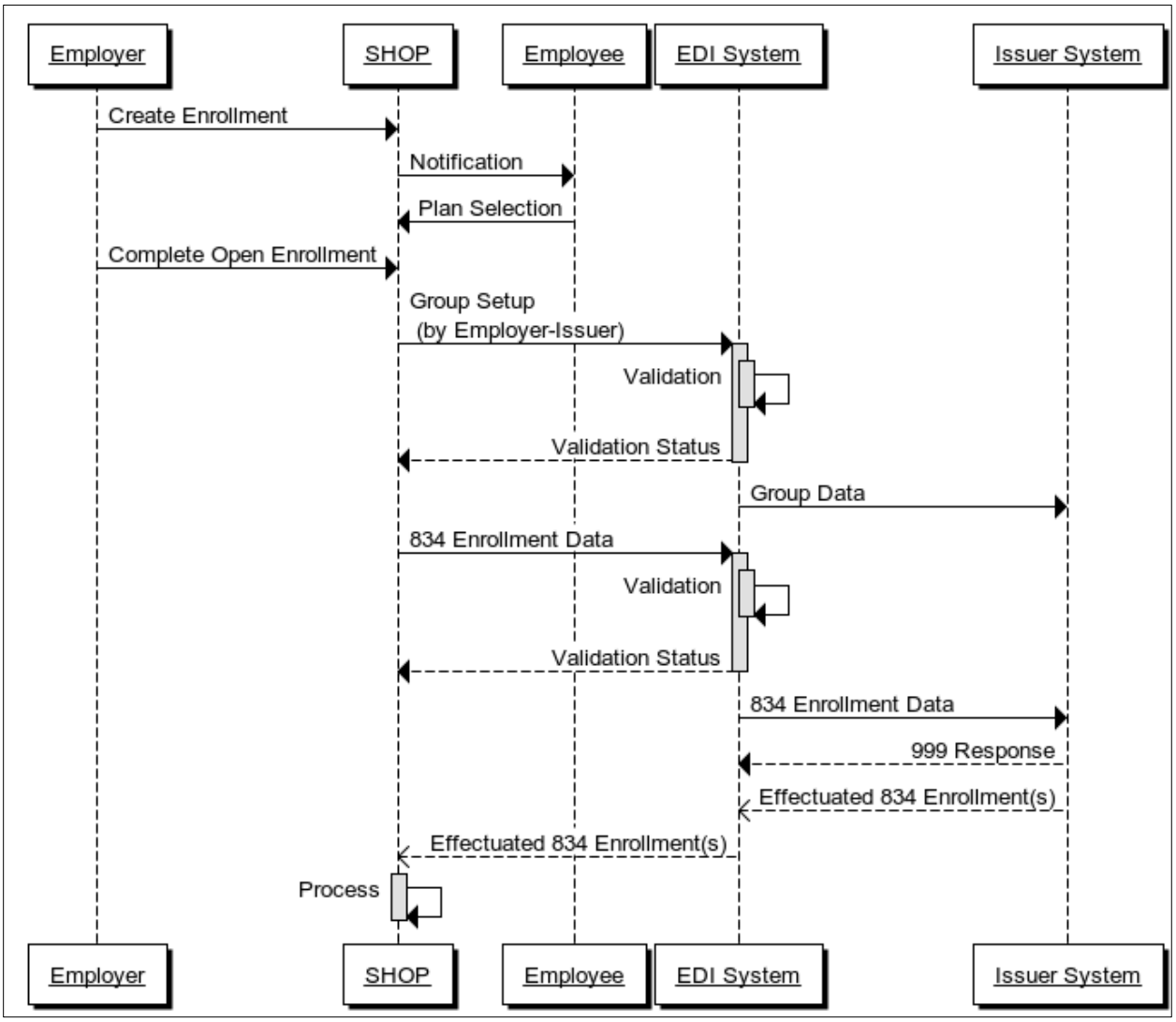
2.9.8 Tobacco Rating at Time of Reenrollment

For passive reenrollments, the FFM will use the same tobacco status as the current year. During the OEP or SEP, enrollees can update their enrollment to change their last date of tobacco use during enrollment periods such that an enrollee would be eligible to go from tobacco-rated to non-tobacco rated and vice versa, with the change taking effect with a prospective effective date basis.

3. ENROLLMENT IN THE FF-SHOPS (APPLICABLE TO FF-SHOP, QHP/QDP)

Employers may complete an initial group enrollment in the FF-SHOPs throughout the year. Exhibit 10 below depicts a high-level end-to-end system flow of the FF-SHOP process for setting up an enrollment group and enrolling in a QHP or QDP. Please refer to Exhibit 10 when reviewing the enrollment instructions in the succeeding sections. This general flow also applies for renewals, with the exception that FF-SHOPs will be sharing group renewal data, instead of initial group enrollment data.

Exhibit 10 – FF-SHOPs High-Level End-to-End System Flow



3.1 ELIGIBILITY

To purchase coverage through an FF-SHOP for the first time, employers, employees, and former employees offered coverage by an employer through the FF-SHOP must complete applications, as required by 45 CFR §155.715(b), to determine their eligibility to participate in the FF-SHOP. Applications can be filed with an FF-SHOP electronically on HealthCare.gov or by phone. CMS, as the operator of the FF-SHOPs, determines eligibility for FF-SHOP applicants. If determined eligible to participate in an FF-SHOP, the qualified employer can select a coverage option to offer to its qualified employees.

For plan years beginning on or after January 1, 2015, the FF-SHOPs may permit a qualified employer to offer all plans within a single metal level of coverage (i.e., platinum, gold, silver, or bronze for QHPs; and high or low for QDPs) to its qualified employees. However, this option (known as employee choice) is available only in some FF-SHOP states for plan years beginning in 2015. A listing of states where employee choice is available for plan years beginning in 2015 is available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2015-Transition-to-Employee-Choice-.html.

If employee choice is available in the state where a qualified employer wants to offer coverage through an FF-SHOP, the employer may choose between offering its qualified employees all QHPs at a single metal level of coverage or offering them a single QHP. If employee choice is available in the state, employers may also choose between offering qualified employees all QDPs at a single level of coverage (high or low) or offering them a single QDP. When offering both QHPs and QDPs, employers may offer only employee choice or a single plan option for both QHPs and QDPs. For plan years beginning on or after January 1, 2016, employee choice will be available to all qualified employers in all states with an FF-SHOP.

After an employer establishes eligibility to participate in an FF-SHOP, makes an offer of coverage to qualified employees, qualified employees elect to accept the employer's offer of coverage, and the group meets applicable minimum participation requirements, the FF-SHOP will electronically transmit the group's enrollment information to the appropriate QHP or QDP issuer(s). This enrollment is subject to cancellation if the FF-SHOP does not receive full premium payment by the 26th day of the month prior to the coverage effective date as described below.

Retirees

An employer may offer coverage to former employees, including retirees, through an FF-SHOP. Information on an 834 enrollment transaction will designate an enrollee as a retiree. Under the current design of the FF-SHOP enrollment system, employers will be able to set one premium contribution percentage for all qualified employees included in the enrollment group and reported on the employee roster, including retirees. Employers will be able to set a contribution percentage for dependents that is different from the percentage contribution from employees, but the contribution percentage must be the same for all dependents. Additionally, all enrollees in an employer group will be rated using the same age rating curve.

COBRA

An employer may provide COBRA continuation coverage through an FF-SHOP. Consistent with their legal obligations as plan sponsors under COBRA, employers should notify enrollees of their eligibility to enroll in COBRA continuation coverage. However, the FF-SHOP online system will not be capable of distinguishing COBRA enrollees from other enrollees, such as employees, on 834 transactions. Employers should contact the FF-SHOP Call Center to add enrollees to COBRA continuation coverage. Like all other premiums, premiums for COBRA enrollees must be remitted to the FF-SHOPs by the employer. Consistent with its obligations under COBRA, the plan sponsor is responsible for billing the COBRA enrollee for any premium amount due. Finally, employers should not remove an enrollee from the roster until any offer of continuation coverage through an FF-SHOP has been declined, continuation coverage is terminated for non-payment of premium, or when the enrollee is no longer eligible for COBRA continuation coverage.

3.2 MINIMUM PARTICIPATION RATES IN FF-SHOPS

Throughout most of the year, in order for a group to enroll in coverage at the time of initial group enrollment or renewal, a minimum percentage of current employees offered coverage through an FF-SHOP must enroll in coverage offered through the FF-SHOP or in certain other types of coverage. If an employer fails to meet the requirement, the group's ability to complete an initial group enrollment or renewal through an FF-SHOP may be restricted to a limited enrollment period (November 15 – December 15) when the minimum participation rate is not calculated.

The default minimum participation rate in FF-SHOPs is 70%. If a state has set a different minimum participation rate by law, or if there is evidence that issuers commonly use a different minimum participation rate, the FF-SHOPs may have opted to use the state-specific rate rather than the 70% rate. See Exhibit 11 below for a list of states where the FF-SHOP will use a different minimum participation rate.

Exhibit 11 – State FF-SHOP Minimum Participation Rates

State	FF-SHOP Minimum Participation Rate
Arkansas	75%
Iowa	75%
Louisiana	75%
New Hampshire	75%
New Jersey	75%
South Dakota	75%
Tennessee	50%
Texas	75%

For plan years beginning prior to January 1, 2016, the minimum participation rate is calculated as the number of currently employed qualified employees accepting coverage under the

employer's group health plan, divided by the number of currently employed qualified employees offered coverage, excluding from the calculation any employees enrolled in coverage through another employer's group health plan or through a governmental plan, such as Medicare Medicaid, or TRICARE. For this timeframe, employees purchasing insurance in the non-group private market (including through the FFMs, SBMs, or SPMs) are included in the FF-SHOP's calculation of a group's minimum participation rate, but do not count toward the employer's ability to meet the rate.[8]

For plan years beginning on or after January 1, 2016, the FF-SHOP minimum participation rate will be calculated in a manner that counts more employees enrolled in coverage outside the FF-SHOPs, thus generally making it easier for employers to meet the requirement. For this timeframe, the FF-SHOP minimum participation rate will be based on the rate of full-time employee participation in the SHOP and in certain other types of coverage, including full-time employees enrolled in coverage through another group health plan, in governmental coverage (such as Medicare, Medicaid, or TRICARE), in coverage sold through the individual market, or in other minimum essential coverage.[9]

The FF-SHOPs will determine if a group meets the minimum participation requirement before sending any enrollment transactions to issuers. A group's minimum participation rate will be calculated only upon its initial enrollment and renewal. The FF-SHOPs will not enforce minimum participation requirements between November 15 and December 15 of each year—including for groups renewing their coverage—pursuant to 45 CFR §147.104. The minimum participation rate requirement and calculation methodology is only applicable to FF-SHOPs. Other SHOPs, including SB-SHOPs and SBMs-FP may authorize a uniform group participation rate for the offering of health insurance coverage in the SHOP, which must be a single, uniform rate that applies to all groups and issuers in the SHOP.

Mid-year fluctuations in a group's participation rate will not affect its ability to maintain coverage through a FF-SHOP. If, at the time of initial enrollment or renewal, a group fails to meet an FF-SHOP's minimum participation rate, it may revise its offer of coverage to encourage more employees to enroll. An employer unable to meet the FF-SHOP's minimum participation rate at the time of renewal may not renew its coverage. Such a group may submit a new application for coverage at another time during the year when the employer meets the minimum participation rate, or between November 15 and December 15.

[8] Please see 45 CFR §155.705(b)(10)(i) and 78 FR 15503.
[9] Please see 45 CFR §155.705(b)(10)(ii).

3.3 INITIAL ENROLLMENT AND COVERAGE EFFECTIVE DATES

Initial Enrollment

A qualified employer may complete an initial group enrollment through an FF-SHOP at any point during the year, provided it meets the minimum participation requirements. An employer can identify a date when it would like initial group coverage to take effect and should set dates for an initial qualified employee enrollment period during the initial group enrollment process that will result in the desired coverage effective date. There is no required minimum length for the initial qualified employee enrollment period. Additionally, because FF-SHOP rates are updated on a quarterly basis, an employer may identify a coverage effective date up to two months in advance so long as the desired effective date is within the current quarter and enrollment is completed according to the timeframe that will result in the desired coverage effective date. Rates for a subsequent quarter will be available by the 16th of the month two months before the rates become effective. Issuers must effectuate all enrollments transmitted by an FF-SHOP unless they receive a cancellation transaction from the FF-SHOP prior to the coverage effective date pursuant to 45 CFR §156.285(c)(8)(iii).

Under 45 CFR §155.725(h)(2), if qualified employee plan selections are made before the 15th of any month, coverage will take effect on the first day of the following month. If qualified employee plan selections are made between the 16th and the last day of any month, coverage will take effect on the first day of the second following month. For example, if qualified employees make their plan selections from February 16, 2016 to February 29, 2016, and the employer submits the group enrollment by February 29, 2016, the group's coverage will be effective April 1, 2016, so long as the first month's premium is paid in a timely fashion and any applicable minimum participation rate requirement is met. Generally, except in states that have elected to merge their individual and small group risk pools under section 1312(c)(3) of the Affordable Care Act,[10] a qualified employer's plan year lasts for 12 months from the initial coverage effective date.

Under 45 CFR §155.725(g), newly qualified employees will have an enrollment period beginning on the first day of becoming a qualified employee. A newly qualified employee will have at least 30 days from the beginning of his or her enrollment period to select a QHP. The enrollment period must end no sooner than 15 days prior to the date that any applicable employee waiting period longer than 45 days would end if the employee made a plan selection on the first day of becoming eligible. The effective date of coverage for a QHP selection received by the FF-SHOP from a newly qualified employee will always be the first day of a month, and will generally be determined in accordance with the enrollment timeframes under

[10] For plan years beginning in 2015 or 2016, no such states are expected to have a FF-SHOP.

155.725(h)(2) that are described above. If the employee is subject to a waiting period consistent with 45 CFR §147.116, the effective date may be on the first day of a later month. However, in no case may the effective date fail to comply with 45 CFR §147.116.

During the initial group enrollment process, an employer will establish a waiting period policy that will apply to newly qualified employees. Available options on the FF-SHOP portal include 0, 15, 30, 45, and 60 days. So long as newly qualified employees have selected their QHPs within the enrollment period specified in 155.725(g), coverage effective dates could be as soon as the first day of the month following the end of their waiting period, unless it would have to be sooner in order for the waiting period to comply with 45 CFR §147.116. Because of operational limitations, employers may change their waiting period policy only once per year, at the time of the group's plan renewal. The FF-SHOP system build does not currently accommodate an approach under which employers could delay a coverage effective date for any subset of the initially enrolled employer group. As such, any qualified employee added to the roster at the time of initial enrollment will not be subject to the group's waiting period for newly qualified employees.

Exhibit 12 – FF-SHOP Coverage Effective Dates

Plan Selection Date	Coverage Effective Date
Between the first and 15th day of the month	First day of the following month
Between the 16th and last day of the month	First day of the second following month

Example

Example 3A: An employer has a newly qualified employee waiting period of 0 days. A newly qualified employee's date of hire is May 10, 2015. The newly qualified employee has an enrollment period to elect coverage and make a plan selection(s) that begins May 10, 2015, and lasts for 30 days, until June 9, 2015. If the newly qualified employee selects coverage by the May 15, the coverage effective date will be June 1, 2015. If the newly qualified employee selects coverage between May 16 and June 9 (within 30 days of becoming eligible on May 10), the coverage effective date will be July 1, 2015.

3.4 SPECIAL ENROLLMENT PERIODS

Qualified employees and their dependents (if the qualified employer offers dependent coverage) may enroll in coverage through an FF-SHOP outside of the initial group enrollment period or the annual open enrollment period if a qualifying event is reported to the FF-SHOP within a specified period of time. Pursuant to 45 CFR §155.725(j) and 155.420, SEPs constitute periods outside of the initial group enrollment period or annual open enrollment period when a qualified employee and (if applicable) his or her dependents may enroll in a QHP/QDP or elect to change a current QHP/QDP selection (if employee choice is offered). The FF-SHOP is responsible for determining whether an enrollee is eligible for an SEP based on eligibility requirements described in 45 CFR §155.725(j), which cross-references most, but not all, of the qualifying

events listed at 155.420(d). Specifically, SEPs described in 45 CFR §155.420(d)(3) and (6) do not apply to SHOP. Employers are not eligible for SEPs.

Pursuant to 45 CFR §155.725(j), SEPs in the FF-SHOPs generally last 30 days from the triggering event with the exception of when an enrollee becomes eligible for loss of coverage under Medicaid or CHIP, in which instances the SEP lasts 60 days from the triggering event.

Enrollment of newly qualified employees is not governed by the same rules that govern FF-SHOP SEPs. Qualified employers may add newly qualified employees (such as newly hired employees) to their roster throughout the plan year pursuant to 45 CFR §155.725(g), as discussed in Section 3.3, Initial Enrollment and Coverage Effective Dates.

Issuers need not determine coverage effective dates for either SEPs or newly qualified employees in the FF-SHOPs. The FF-SHOPs will make these determinations and include the appropriate effective dates on the 834 enrollment transactions.

Pursuant to 45 CFR §155.725(j)(5), the effective dates of coverage for SEPs in the FF-SHOPs are determined using the provisions of §155.420(b). Under 155.420(b)(1), regular coverage effective dates for a QHP/QDP selected by an enrollee during an SEP are:

- The first day of the month following plan selection if selection took place between the 1st and 15th day of any month; or
- The first day of the second month following plan selection if selection took place between the 16th and the last day of any month.

Due to operational limitations, the FF-SHOP will be using coverage effective dates pursuant to 45 CFR §155.725(h)(2) for SEPs for enrollees who gain dependent(s) through a child support order or other court order.

However, if an enrollee experiences an LC, such as marriage, birth, adoption, or placement in foster care, the coverage effective date is retroactive to the triggering event. Coverage effective dates under the SEP will also depend on the qualified employee's and/or dependent's specific situation. Exhibits 13 and 14 summarize and provide examples of coverage effective dates for various SEPs within the FF-SHOP.

Exhibit 13 – FF-SHOPs Coverage Effective Dates Summary

SEP Event	FF-SHOP Coverage Effective Date	Regulation
Loss of Coverage (Loss of MEC, Medicaid, or CHIP)	First day of the month following the loss of coverage or of the month following plan selection, depending on when the plan selection is made.	45 CFR §155.420(d)(1)

SEP Event	FF-SHOP Coverage Effective Date	Regulation
Permanent Move/Relocation	**Plan selection between the 1st and15th of the month**: First day of the following month **Plan selection between the 16th and last day of the month**: First day of the second following month	45 CFR §155.420(d)(7)
Marriage	First day of the month following plan selection	45 CFR §155.420(d)(2)
Birth, Adoption, or Foster Care	Date of birth, adoption, placement for adoption, or placement in foster care	45 CFR §155.420(d)(2)
Enrollees Who Gain Dependent(s) Through a Child Support Order or Other Court Order	For operational limitations, regular effective dates apply. **Plan selection between the 1st and 15th of the month**: First day of the following month **Plan selection between the 16th and last day of the month**: First day of the second following month	45 CFR §155.420(b)(2)(v)
Native American Status	**Plan selection between the 1st and 15th of the month**: First day of the following month **Plan selection between the 16th and last day of the month**: First day of the second following month	45 CFR §155.420(d)(8)

Exhibit 14 – FF-SHOPs SEP Effective Date Examples

Triggering Event	Triggering Event Date	Enrollment Period Start Date	Enrollment Period End Date	Plan Selection Date Examples	Enrollment Effective Dates
Relocation	4/1	4/1	5/1	4/15	5/1
Relocation	4/10	4/10	5/10	4/16	6/1
Relocation	3/20	3/20	4/19	4/16	6/1
Birth	6/1	6/1	7/1	6/29	6/1
Birth	8/25	8/25	9/24	9/15	8/25
Birth	12/26	12/26	1/25	1/13	12/26
Loss of MEC	4/28	4/28	5/28	4/29	5/1
Loss of MEC	4/15	4/15	5/15	5/2	6/1
Loss of MEC	5/12	5/12	6/11	6/7	7/1
Loss of	4/28	4/28	6/27	5/20	6/1

Triggering Event	Triggering Event Date	Enrollment Period Start Date	Enrollment Period End Date	Plan Selection Date Examples	Enrollment Effective Dates
Medicaid					
Loss of Medicaid	4/15	4/15	6/14	6/12	7/1
Loss of CHIP	5/12	5/12	7/11	7/10	8/1
Marriage	4/12	4/12	5/12	4/29	5/1
Marriage	7/1	7/1	7/31	7/20	8/1
Marriage	5/15	5/15	6/14	6/13	7/1

HHS-Granted SEPs

Under special circumstances, CMS will be providing HHS-granted SEPs, which include circumstances due to enrollment errors, exceptional circumstances, misrepresentations, and plan display errors. Enrollees seeking an HHS-granted SEP will need to contact the FF-SHOP Call Center, which will work with CMS caseworkers to determine an enrollee's eligibility for a HHS-granted SEP. The HHS-granted SEPs that will be supported by the FF-SHOP include:

- **Enrollment error SEPs (granted under 155.420(d)(4)):** when qualified employees selected a plan by the appropriate deadline, but due to a technical error, the enrollment either was not processed correctly or the issuer does not have the enrollment.
- **Exceptional circumstance SEPs (granted under 155.420(d)(9)):** when qualified employees or dependents experience a situation that the Marketplace determines has prevented enrollment in a plan by the applicable deadline, such as a natural disaster or medical emergency. Note that exceptional circumstance SEPs may be granted for additional situations in accordance with guidelines issued by HHS.
- **Misrepresentation SEPs (granted under 155.420(d)(4)):** when misconduct by individuals or entities providing formal enrollment assistance (like a Navigator, a Call Center Representative, or an A/B registered with the FFM) results in the qualified employee's or dependent's unintentional, inadvertent, or erroneous enrollment or non-enrollment in a plan.
- **Plan display error SEPs (granted under 155.420(d)(4)):** when incorrect plan data, such as plan benefit and cost-sharing information was displayed on Plan Compare at the time the qualified employee selected the plan.

SEPs due to enrollment errors and exceptional circumstances can be granted when a qualified employee or dependent has not yet enrolled in a plan. Misrepresentations and plan display error SEPs may be granted after an enrollment has been effectuated.

Pursuant to 45 CFR §155.735(d)(2), terminations are effective on the last day of the month in which the FF-SHOP receives notice of an enrollee's change from one QHP to another during an SEP. Notice must be received by the FF-SHOP prior to the proposed date of termination.

Coverage Effective Dates for HHS-granted SEPs other than Plan Display Errors

For HHS-granted SEPs other than plan display errors, the date that the enrollment error, exceptional circumstance, or misrepresentation occurred is the event that triggers the SEP. Pursuant to 45 CFR §155.725(j)(5) and 155.420(b)(2)(iii), a Marketplace may provide for a coverage effective date that is either: (1) based on the date of the SEP-triggering event, which provides qualified employees with their initially intended coverage effective date; or (2) based on the date of the plan selection during the SEP window, which provides qualified employees and dependents with their regular effective dates.

In the FF-SHOPs, qualified employees and dependents will be eligible to receive their intended coverage effective date if they take timely action to contact the FF-SHOP Call Center to request an SEP before the initially intended coverage effective date passes. Taking action before the coverage effective date passes indicates to CMS that the qualified employee or dependent had intended to enroll in coverage by the initially intended coverage effective date and would have had their coverage effectuated had the event that triggered the SEP not occurred.

Plan Display Errors

Plan display errors occur when an issuer or Marketplace error results in incorrect plan data being displayed to qualified employees on HealthCare.gov's Plan Compare. This can include, but is not limited to, errors in premium, benefit, and cost sharing. A qualified employee affected by plan display errors may be eligible for an SEP to return to the Marketplaces and select another plan, if one is available (that is, if the employer is offering a choice of plans).

Unlike the other HHS-granted SEPs, qualified employees and dependents eligible for a plan display SEP in an employee choice environment are typically already enrolled in a plan, which requires the SEP process to accommodate the additional complexity of terminating enrollment in the original plan if the qualified employee or dependent selects a different plan during the SEP period.

Identifying and Resolving Plan Display Errors

Plan display errors are identified after CMS investigates potential display discrepancies raised by issuers or qualified employees and dependents or noticed by CMS. Marketplace plan display errors include situations where coding on HealthCare.gov causes benefits to display incorrectly, or where CMS identifies an incorrect plan data submission or a discrepancy between an issuer's plan data and its state-approved form filings. If a coding error is identified, CMS determines whether other plans are affected by the same error and reaches out to other affected issuers. When a plan display error is identified, CMS works with the issuer to correct the error as quickly as possible to ensure that future enrollments are based on accurate plan data.

In some cases, the corrected plan data either reduces a benefit or increases costs to qualified employees and dependents. CMS works with the issuer and a state's Department of Insurance to arrive at a solution that has a minimal impact on impacted qualified employees and dependents, and ensures, to the extent possible, that they are not negatively affected by this Marketplace or issuer error.

Generally, the most straightforward and consumer-friendly resolution is for issuers to honor the benefit as it was displayed incorrectly for affected enrollees. If the issuer honors the benefit and administers the plan as it was incorrectly displayed for the affected enrollees, no further action is needed. Employers making decisions based on inaccurate plan data always have the option to terminate their existing coverage and sign up for new coverage.

Issuers That Do not Honor the Plan Information That Displayed Incorrectly

CMS is committed to ensuring, to the extent possible, that qualified employees and dependents are not negatively affected by Marketplace or issuer plan display errors. Depending on the significance of the plan display error, there are several options to mitigate the impact on the qualified employee or dependent.

If the plan display error is significant and it is reasonable to expect that it may have affected a qualified employee's or dependent's enrollment decision, then qualified employees and dependents will be notified of the error and provided a plan display error SEP. When employee choice is available, the SEP will provide qualified employees with the option to select another plan—either from the same issuer or another issuer available to the qualified employee or dependent. If qualified employees decide not to select another plan or when employee choice is not available, the qualified employee and dependent can stay enrolled in their existing plan with correct benefits (that is, not the benefits that were displayed incorrectly).

If a plan display error is minor and likely has little impact on qualified employees and dependents, qualified employees and dependents may still be eligible for an SEP at their request.

Processing Plan Display Error SEPs

CMS allows a qualified employee or dependent who is already enrolled in a plan but is eligible for an SEP to select a new plan by calling the FF-SHOP Call Center. The FF-SHOP Call Center will help the qualified employee update information as needed and complete the process of selecting a plan. Qualified employees generally have 30 days from the notification of the plan display error to select a new plan.

Under 45 CFR §155.725(j)(5) and 155.420(b)(2)(iii), a Marketplace may provide for a coverage effective date that is either: (1) based on date of the SEP-triggering event, which provides the enrollee his or her initially intended coverage effective date; or (2) based on the date of the plan selection during the SEP window, which provides the enrollee regular effective dates. Accordingly, the new coverage generally will be effective based on the date the new plan was selected. In some cases, qualified employees and dependents can elect retroactive coverage to the

initially intended coverage effective date; however, the use of retroactive coverage dates will be limited to those circumstances where it is necessary to avoid significant economic harm to qualified employees or dependents.

The FF-SHOP will terminate the coverage when the qualified employee has selected another QHP during an SEP.

3.5 PLAN COMPARE AND PLAN SELECT

Qualified employers and qualified employees can view and select QHPs and QDPs (if the qualified employer offers dental coverage) using the plan comparison tool in the FF-SHOPs. There are slightly different shopping experiences for qualified employers and qualified employees applying through HealthCare.gov and qualified employers and qualified employees applying and enrolling by phone.

Online Functionality

Employers offering coverage through an FF-SHOP may elect to offer their qualified employees a single medical plan (and can also opt to offer a single dental plan) in which the qualified employees may enroll. Additionally, in many states with an FF-SHOP for coverage beginning in 2015, and in all states with a FF-SHOP for coverage beginning in 2016 and beyond, the qualified employer may elect to offer all of the plans within an actuarial value level to its qualified employees (referred to as employee choice). The process for qualified employers and qualified employees differs depending on whether the employer elects to offer employee choice or a single plan. Below, we describe the processes for employers and qualified employees under both scenarios.

Plan Compare for Qualified Employers and Qualified Employees

Qualified employers and qualified employees who have received an eligibility determination from a FF-SHOP can select, offer, and/or enroll in a QHP and QDP while shopping online. Qualified employers and qualified employees may use tools to assist them in determining the best coverage for their needs, including real-time premium quotes based on the qualified employer's roster of qualified employees and the qualified employer's enrollment expectations for qualified employees and their dependents, detailed plan information, and assistance such as definitions and explanatory text.

After a qualified employer selects which QHP or QDP or coverage levels he or she wishes to view, he or she is shown the available plan results. Qualified employers are shown only QHPs that they can offer based on the information provided in their applications. For example, a qualified employer is not shown QHPs with service areas that do not include the employer's applicable address provided on his or her application (principal business address or an eligible employee worksite), and qualified employees offered employee choice will see only the plans at the qualified employer's chosen actuarial and/or dental coverage value level that are available in the applicable geographic area.

After the qualified employer selects the plan or plans he or she wishes to offer, qualified employees can see the offered plan(s) and make enrollment decisions. If employee choice is offered, the qualified employees can compare multiple plans before making a selection. If an employer makes dental coverage available and offers employee choice, and a qualified employee has opted to enroll in dental coverage, the employee will view the dental plan comparison and select a dental plan after the employee has selected a QHP. Unless otherwise noted, the descriptions that follow apply to both the QHP and the QDP selections.

Plans are displayed in three views: (1) the initial Plan Results view that presents summary information; (2) a Plan Side-by-Side view that facilitates more detailed comparison; and (3) a Plan Details view that shows a single plan with comprehensive information. A plan may be selected to begin the enrollment process from any of the three views.

Plan Results View

In the Plan Results view, the FF-SHOP plan comparison tool will sort and display plans from the lowest to the highest monthly premium. For example, if bronze plans are selected, the bronze plans will be sorted and displayed from the lowest to the highest monthly premium. A qualified employer or qualified employee (if employee choice is offered) may re-sort plans based on other criteria, such as employer cost, qualified employee's share of premium cost, and individual deductible.

Summary-level plan attributes are displayed in the results view, including the full monthly premium amount, the amount of both the employer and qualified employee contributions to the cost of premiums, deductibles, out-of-pocket maximums, and an enrollee's copays for doctor visits and prescriptions. Cost sharing amounts are displayed for in-network covered services for either self-only or non-self-only coverage (e.g., a multi-person group will see a family deductible).

Qualified employers and qualified employees (if employee choice is offered) can select up to three plans from the Plan Results view for more detailed side-by-side comparisons. The plan comparison tool or Plan Side-by-Side view is useful if a qualified employer or qualified employee wishes to compare the benefits and cost sharing of various plans. Each plan is displayed in column format facilitating side-by-side comparison of specific benefits and costs.

Qualified employers and qualified employees can also use the Plan Details view to review plan information. In Plan Details, a plan is seen in isolation with the same benefit attributes as displayed in the Side-by-Side view, and, if the plan reimburses for the use of providers outside of its network, such cost sharing for out-of-network providers is also visible.

Qualified employees will see all plans made available by the employer. If employee choice is offered, qualified employees will see all available plans at the selected coverage level. When employee choice is not available, qualified employees will see only the QHP and QDP (if applicable) selected by the qualified employer. Qualified employers and qualified employees can

access the issuer provider directory and Summary of Benefits and Coverage via a link in each plan's display.

Filters

Qualified employers and qualified employees (when employee choice is available) can filter their QHP results to help them select the most desirable plans. Exhibit 15 below details the filters that are available.

Exhibit 15 – Filters for QHP Results

Filtering Option	Description
Plan Category	Assignment of plan coverage levels designated by average cost and coverage of benefits: bronze, silver, gold, and platinum (e.g., on average, platinum covers health benefits with lower enrollee cost sharing than bronze, but has more expensive premiums).
Estimated Employer Contribution	Estimated premium amount that the employer is responsible for paying.
Estimated Employee Contribution	Estimated premium amount that the employee is responsible for paying
Yearly Deductible (per employee)	The required amount employees must pay before their health coverage begins to cover health care costs.
Yearly Deductible (per family)	The required amount a family must pay before their health coverage begins to cover health care costs.

Plan Side-by-Side View

Qualified employers and qualified employees (when employee choice is available) can select several plans for more detailed side-by-side comparisons. Each plan is displayed in column format facilitating comparison of specific benefits. Exhibit 16 below details the comparison categories and information displayed in side-by-side comparisons of QHPs.

Exhibit 16 – QHP Benefit Attributes Displayed in Side-by-Side Comparison

Comparison Category	Information Displayed
Costs for Medical Care	• Primary care doctor visit • Specialist visit • X-rays and diagnostic imaging • Laboratory and outpatient professional services • Hearing aids • Routine eye exams for adults • Routine eye exams for children • Eyeglasses for children • Health Savings Account eligible plan

Comparison Category	Information Displayed
Prescription Drug Coverage	• Generic drugs • Preferred brand drugs • Non-preferred brand drugs • Specialty drugs • List of covered drugs • Three month in-network mail order pharmacy benefit • Prescription drug deductible • Prescription drug out-of-pocket maximum
Access to Doctors and Hospitals	• Provider directory • National provider network
Hospital Services	• Emergency Room care • Inpatient physician and surgical services • Inpatient hospital services
Cost and Coverage Examples	• Having a baby deductible • Having a baby copayment • Having a baby coinsurance • Having a baby limit • Managing diabetes deductible • Managing diabetes copayment • Managing diabetes coinsurance • Managing diabetes limit
Adult Dental	• Routine dental care • Basic dental care • Major dental care • Orthodontia • Find dentists
Child Dental	• Dental check-up • Basic dental care • Major dental care • Medically necessary orthodontia
Medical Management Programs	• Disease management programs offered

Comparison Category	Information Displayed
Other Benefits	• Acupuncture • Chiropractic care • Infertility treatment • Mental/Behavioral health outpatient services • Mental/Behavioral health inpatient services • Habilitative services • Bariatric services • Outpatient rehabilitative services • Skilled nursing facility care • Private-duty nursing
Plan Documents	• Plan brochure • Summary of Benefits and Coverage

Plan Details View

Qualified employers and qualified employees can also select a plan within the Plan Details view. In Plan Details, a QHP is seen in isolation with the same benefit attributes as are displayed in the Side-by-Side view, as well as out-of-network cost sharing.

Where qualified employees are offered only a single QHP and/or QDP by their employers, the qualified employees will be routed directly to the Details View during their application process. Qualified employees will view only the QHP and/or QDP offered to them by their employer.

Qualified Employers: Select Offerings

A qualified employer will determine whether he or she wishes to offer employee choice by making all plans within a given actuarial (metal) (and/or dental) level available, or whether to offer a single plan. When the employer is ready, the FF-SHOP system will prompt the employer for its decision and the employer can then select the metal or dental level he or she wishes to offer, or select a plan to offer by pressing the “Select” button available in any of the three views (i.e., Results, Side-by-Side, and Details). If the employer wishes to offer a single plan, the qualified employer will select a QHP and can also opt to offer a single QDP. A qualified employer is not required to select a QDP to offer.

Enrollment for a qualified employee works similarly. If employee choice is offered, the qualified employee may click the “Enroll” button from any of the three views described above. If the employee is offered only a single plan, the employee may make only this selection from the Plan Details view to which he or she was originally directed. Under this option, a qualified employee may enroll only in a single QHP/QDP offered by its employer.

Qualified Employees: Employee Choice

If a qualified employer offers employee choice to its qualified employees, qualified employees will have a similar plan comparison experience to the employer. First, upon a positive eligibility determination, the qualified employee will be directed to the Plan Results page with similar functionality to that described for a qualified employer above. On this page, the qualified employee may view a list of all medical plans for which the qualified employee is eligible. Here, this means all available plans within the actuarial value level selected by the qualified employer. After viewing all available plans, a qualified employee can decide to accept or decline coverage.

When a qualified employer offers employee choice with respect to dental coverage, qualified employees will view a list of all dental plans for which they are eligible based on the dental level of coverage (high or low) selected by the qualified employer.

Similar to the employer, the qualified employee may then use the comparison view and detailed plan view to view the benefits and cost sharing for the plans offered to the employee. Premium costs for all available plans are displayed to the employee net any applicable employer contribution.

Qualified Employees: Single Plan Offered

In the case of qualified employees who are offered a single plan by their employer, upon receiving a positive eligibility determination, the qualified employees are directly routed to the Plan Details page where they will view the medical and (if applicable) dental plan offered by their employer. In addition to displaying various benefits, this page will display the employees' premium costs net any applicable employer contribution. Beginning the enrollment process only requires the qualified employees to select the "Enroll" button for this plan.

Qualified Dental Plans in FF-SHOP

For plan years beginning on or after January 1, 2015, in states with an FF-SHOP where employee choice is an option for employers, the FF-SHOP will also permit a qualified employer to offer its qualified employees a range of QDPs, specifically, all QDPs within a single coverage level (high or low). As discussed above, employee choice is not available in all states with an FF-SHOP for plan years beginning in 2015. A listing of states with employee choice for plan years beginning in 2015 is available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2015-Transition-to-Employee-Choice-.html. For plan years beginning on or after January 1, 2016, all employers (in all states with an FF-SHOP) will be able to offer their qualified employees a range of QDPs or a single QDP.

Premiums are honored by the QDP issuer for the 12-month plan year, and enrollment transactions for QDPs will be facilitated through the FF-SHOP using 834 enrollment transactions.

Dental Changes for Plan Years Beginning as Early as 2016

For plan years beginning as early as 2016, employers offering coverage through the FF-SHOPs will be able to offer dental coverage without also having to offer medical coverage. When only dental coverage is offered by an employer and dependent dental coverage is also made available by the employer, a qualified employee would have to enroll in dental coverage before dependents of that qualified employee will be able to enroll in dental coverage, as is the case for medical coverage.

If an employer offers both medical and dental coverage to qualified employees and their dependents through an FF-SHOP, and a qualified employee enrolls in both medical and dental coverage, the qualified employee's dependents will be able to enroll in either the medical or dental coverage selected by the qualified employee, or enroll in both. Qualified employees can decide which dependents are enrolled in each plan, as long as the qualified employee is enrolled in the plan.

Select a Plan

If a qualified employer does not make employee choice available, the qualified employer may select a plan to offer by pressing the "Select" button available in any of the three views (i.e., Results, Side-by-Side, and Details). After a qualified employer selects a QHP, he or she will be prompted to select a QDP.

Enrollment for a qualified employee works similarly. However, a qualified employee is able to enroll only in a QHP or QDP offered by its employer. When employee choice is not available, qualified employees will be able to select only the plan offered by their employers.

Confirm QHP/QDP Selections

At the close of the enrollment period for qualified employees, the qualified employer is shown a final confirmation of all qualified employee plan selections. Once the qualified employer confirms the selection(s) by clicking the "Confirm" button, the FF-SHOP system records the selection(s) and generates a group enrollment transaction (which is sent immediately upon submission) and an 834 enrollment transaction (which is batched with other similar transactions and sent once during the business day to each respective QHP issuer). The same process is used regardless of whether the qualified employer offers employee choice.

Education

When making coverage decisions on HealthCare.gov, qualified employers and qualified employees will receive on-screen tips about basic health insurance concepts. The FF-SHOP presents information regarding the general trade-off between premium and out-of-pocket medical costs, the categories of essential health benefits included in all plans, and plan grouping according to the actuarial value level (i.e., platinum, gold, silver, and bronze).

As the last step before viewing available plans, qualified employers are asked which QHP or QDP or coverage level (i.e., metal level of coverage for QHPs, high or low coverage for QDPs) they would like to see displayed in Plan Compare. Once in the Plan Results view, a qualified employer can change the coverage level or issuer plans displayed.

FF-SHOP Marketplace Call Center Functionality

Qualified Employers

There is a single call center for the FF-SHOPs. Qualified employers who have applied online and have been determined eligible to purchase coverage through an FF-SHOP may use the FF-SHOP Call Center to make decisions about what coverage to offer and make changes to their group. Qualified employers must create a HealthCare.gov account on their own. FF-SHOP Call Center customer service representatives will not be able to create an account on behalf of the qualified employer, but can walk the qualified employer through the process. Using the same online tools available to the qualified employers through HealthCare.gov, the FF-SHOP Call Center customer service representative will guide the qualified employer through necessary decision points, such as whether to elect to offer multiple plans to its employees through employee choice, what plan to offer if only a single QHP (and/or QDP) is offered, and determining how much to contribute towards enrollee premiums. After employees have completed their initial open enrollment period, the call center representative can also help the qualified employer make his or her first month's premium payment. The FF-SHOP Call Center customer service representatives will not recommend specific plans, levels of coverage, or amounts to contribute towards the cost of coverage.

Qualified Employees

FF-SHOP Call Center customer service representatives are also available to assist qualified employees. FF-SHOP Call Center customer service representatives will not be able to create a HealthCare.gov account on behalf of the qualified employee so qualified employees must establish their own accounts. The customer service representatives will use the same tools available to the qualified employees through HealthCare.gov. The customer service representative will describe to the qualified employee the online Plan Compare functions, ask about the qualified employee's preferences, and (if employee choice is offered) guide the qualified employee through the plan selection process. Where an employer elects to offer a single QHP (and/or QDP), the call center representative will describe the employer's offer of coverage to the qualified employee and the QHP (and/or QDP) plan details. The FF-SHOP Call Center representative may then record plan selections for the qualified employee (and if applicable, the qualified employee's dependents). FF-SHOP Call Center representatives will not recommend a specific plan when a qualified employee has a choice between plans, but will instead describe the characteristics of each plan to the qualified employee, as displayed to the representative by the online tool described below.

The FF-SHOP Call Center also provides assistance to A/Bs registered with the FFM, Navigators, and other Marketplace-approved assisters who are working with FF-SHOP consumers. Issuers can also contact the FF-SHOP Call Center with enrollment and payment related matters.

Back Office System Functionality

There are limited circumstances when, due to the current configuration of the FF-SHOP system, it is necessary to contact the FF-SHOP Call Center to make changes to a qualified employer or qualified employee account in an FF-SHOP. These modifications are made to accommodate specific enrollee demographic information updates or account alterations that are outside the scope of routine system functionality. These changes can be made by specialized FF-SHOP Call Center representatives at the request of CMS, a qualified employer, or a qualified employer's designated A/B. Most of these enrollment and account updates will be communicated to issuers via 834 maintenance transactions.

The following demographic back office changes are currently supported in FF-SHOPs:

- Changes to the date of birth (DOB) of an enrollee after submission of the application. Collection of any additional premium amounts owed as a result of any resulting rate change would begin the first of the following month.
- Changes to the Social Security number (SSN) of an enrollee after submission of the application.
- Changes to the gender of an enrollee after submission of the application.
- Changes to the name of a qualified employee, qualified former employee, or business owner enrollee after submission of the application. (Qualified employees, qualified former employees, and business owner enrollees will be able to change the name(s) of their dependent(s) on HealthCare.gov.)
- Changes mid-year to an enrollee's tobacco status at the beginning of a plan year. Collection of any additional premium amounts owed as a result of any rate change would begin the first of the following month.

The following qualified employer and qualified employee account back office changes are currently supported in FF-SHOPs:

- Changes to the eligibility status of a qualified employee (e.g., after a successful eligibility appeal), and the ability to backdate the coverage effective date as far back as the date the qualified employer signed up for coverage. Changes to the effective date for qualified employees would also apply to any of the qualified employee's dependents whose enrollment was linked to the qualified employee's eligibility.
- COBRA: In circumstances where an employer terminated the coverage of a former employee before determining whether the former employee wished to elect COBRA, adding a former employee (and/or dependents) to the employee roster, and backdating the coverage effective date back to when the previous coverage ended so there is no gap in coverage.

- Backdating the coverage termination date to the end of the death month for a deceased enrollee (when the report of death happens after an operational deadline of 30 days following the death of the enrollee).
- Backdating the coverage termination effective date of an employee no longer employed by a company (and his/her dependents) to the end of the dismissal month when the employer misses the deadline in 155.735(d)(2) to report the termination prior to the proposed date of termination.
- Opening a 30- or 60-day SEP, including for circumstances when an A/B, Navigator, call center representative, and/or issuer makes a documented error, or there is a known system failure preventing an enrollee from enrolling in a timely manner.
- Opening a 30-day SEP for the birth of a dependent that was not reported within the allotted timeframe.
- Extending the employer's enrollment period end date for four days to provide flexibility to employers needing assistance when the FF-SHOP Call Center is closed.
- Changing the employer's premium contribution percentage. New contribution percentages would be effective on the first of the following month.
- Allowing an employer to change its newly qualified employee waiting period one time each year.
- Changing the mail preferences for notices and invoices.
- Changing the preferred method of contact for the qualified employer.
- Making a premium payment on behalf of a qualified employer who does not wish to make a payment online. Only specialized call center representatives are able to accept payments over the phone from employers.

Data Correction Process

When the FF-SHOP Call Center is unable to make back office changes to a qualified employer or qualified employee account in the FF-SHOP system for exceptional circumstances, CMS may need to manually generate enrollment and maintenance transactions or make updates to the FF-SHOP system database. Examples of FF-SHOP data corrections include: (1) adding, removing, or altering a data element when it causes an 834 transaction to fail EDI validation; (2) updating an employer identification number (EIN) that was incorrectly entered by an employer; (3) making changes to the coverage start or end date that cannot be accommodated by the FF-SHOP Call Center's back office system functionality; and (4) reinstating an enrollee who was inappropriately cancelled or terminated. Most of these enrollment and account updates will be communicated to issuers via 834 enrollment or maintenance transactions.

3.6 ENROLLMENT TRANSACTIONS

Initial Group Enrollment Transaction

In the FF-SHOPs, once a qualified employer completes the initial group enrollment process, the FF-SHOP system generates and sends a group enrollment transaction to each QHP issuer offering a QHP in which a qualified employee of the employer elected to enroll, regardless of

whether an employer has made an immediate payment to the FF-SHOP at the time of the initial group enrollment. A group enrollment transaction is used by the FF-SHOP system to transmit detailed information to issuers regarding the employer offering group coverage through an FF-SHOP. Since 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. Detailed information regarding the Initial Group Enrollment transaction can be found on REGTAP and zONE in the Federal Data Services Hub (DSH) Employer Group Business Service Definition. 834 transactions will not be sent until an employee has made a plan selection, and the coverage effective date will be included in the 834 transaction. The 834 enrollment transactions will be batched and sent once per business day to issuers. Additional information, including the specification for the form and manner of the information transmitted on 834 enrollment transactions, can be found in the Companion Guide.

Enrollment Reconciliation for Plan Years Beginning in 2014

The FF-SHOPs have developed an interim process to support reconciliation of all direct enrollments that took place prior to November 15, 2014, in coverage that took effect during plan years that began in 2014, during the period when online enrollment through the FF-SHOP system was not available. All FF-SHOP QHP and QDP issuers offering such coverage should submit a monthly file of enrollees to CMS. This process began in August 2014. The data is to be extracted from the issuer's system on the 15th of each month and transmitted to CMS within five business days of the 15th of the month. The file must be in a Microsoft Excel (Version 7 or greater) format with all cells formatted as text. This process will continue until the end of all plan years that began in 2014. Because a plan year that began in 2014 might end as late as November 30, 2015, the 2014 enrollment reconciliation process may continue until January or February 2016—when all new hire and special enrollments have been processed.

Each issuer file should include a record for each enrollee who is, or has been, covered in a QHP or QDP through an FF-SHOP since January 1, 2014. This would include anyone with active coverage or terminated coverage. Enrollees who cancelled coverage prior to the effective date (for whom coverage has never been active) should not be included on the monthly file. The file will be an aggregate of all enrollees from the first day of the plan year through the end of the plan year. Detailed technical specifications and file naming conventions for the file can be found on zONE and on RegTap.

Enrollment Reconciliation for Plan Years Beginning in 2015 and Beyond

For plan years beginning on or after January 1, 2015, CMS will leverage the Enrollment Reconciliation fields, file formats, and dispositions used in the individual market FFMs for FF-SHOPs. The FF-SHOP process will focus on only a subset of applicable elements. Some elements from the individual market Marketplaces, such as APTCs and CSRs, are not applicable. The FF-SHOP reconciliation process will focus on only a monthly snapshot of active enrollments for the previous month.

The FF-SHOPs and issuers will send monthly reconciliation files through the Exchange Managed File Transfer (MFT) process. Files are validated and data is compared between the FF-SHOP and issuer files. The FF-SHOPs will contact issuers if files fail validation.

Additional details and technical specifications can be found on REGTAP.

3.7 APPLICATION AND ENROLLMENT CHANGES

Employer Changes

Employers will not be able to change a coverage offer after the initial group enrollment or renewal process is completed without call center intervention. Qualified employers wanting to make coverage or contribution changes affecting the entire group after the initial group enrollment or renewal process is complete should cancel or terminate coverage (if coverage has already taken effect), and start the application process over again for a future coverage month. Employers and qualified employees may cancel their coverage up to 11:59 pm ET on the date prior to the coverage effective date. Employers must report to the FF-SHOPs, pursuant to 45 CFR §157.205(f), information on newly qualified employees and newly eligible dependents added to their rosters after the initial enrollment process is complete. Newly qualified employees added to a roster after the initial group enrollment will be subject to the employer's waiting period policy established at the time of initial enrollment. Employers will not be able to change their QHP and QDP selections or their selection of an actuarial value and dental coverage level to offer after the group enrollment process is completed.

Qualified Employee Changes

If information included in a qualified employee's application changes during the year, the FF-SHOP system can process the change only if it is submitted by the qualified employer. Examples of changes that may be reported to an FF-SHOP by employers include changes of dependent status and changes of employment status that affect the employee's or dependent's eligibility and enrollment status (i.e., if an employee is no longer employed full time and the employer offers coverage only to full-time employees, or if an employee is no longer employed by the qualified employer). Qualified employees may make limited changes online, such as change of mailing address and phone number. Qualified employers and qualified employees have three methods to report changes, as described in Exhibit 17 below.

Exhibit 17 – Reporting Changes to the FF-SHOP

Method	Steps
Website	Log on to the HealthCare.gov website, under the MyAccount page, to enter the Employer or Employee portal.
Phone	Contact the FF-SHOP Call Center (800-706-7893) – (TTY: 711)

Method	Steps
In Person	Visit local A/Bs registered with the FF-SHOPs or HHS Navigator grantees. Navigators will be able to walk qualified employers and qualified employees through the online process with the enrollee logged into their own MyAccount. In addition to assisting enrollees logged into their own MyAccount, A/Bs may also have the ability to log into the FF-SHOP A/B portal to make changes to FF-SHOP accounts on behalf of an employer (when authorized to do so).

Example

Example 3B*:* An employer offers its employees a 25% contribution to premium costs for a single QHP and completes the FF-SHOP group enrollment process. Following the employer's initial group enrollment process, the employer wants to change the amount it contributes to premium costs. To make this change without FF-SHOP Call Center intervention, the employer will have to cancel (or terminate) coverage and start the application process over again for a future coverage month.

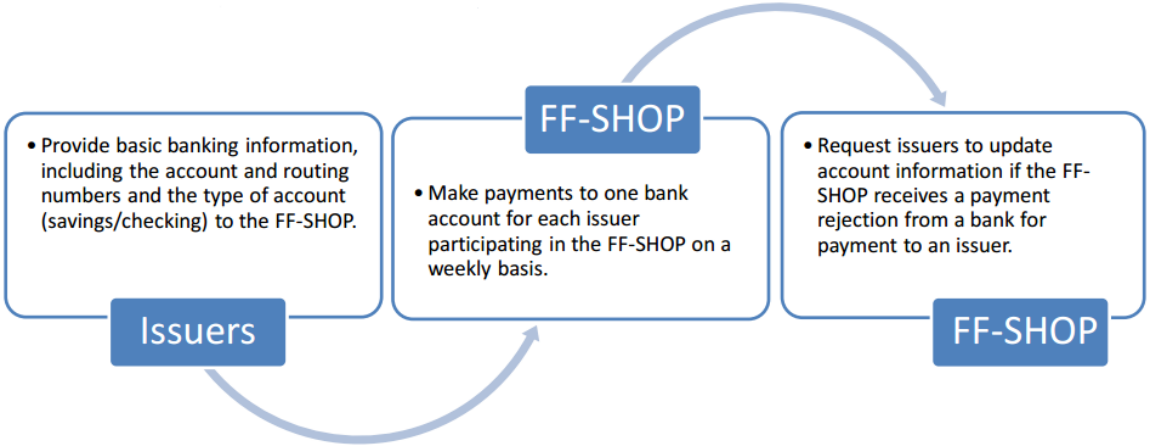
3.8 PREMIUM PAYMENT AND PREMIUM AGGREGATION SERVICES IN THE FF-SHOPS

Premium Aggregation Services

The FF-SHOP system is the enrollment and payment system of record for all enrollments for FF-SHOP plan years beginning on or after January 1, 2015. Qualified employers whose groups are enrolled in coverage through an FF-SHOP in those plan years will receive one bill from the FF-SHOP and make one payment to the FF-SHOP, which will provide premium aggregation services for all qualified employers participating in a FF-SHOP. Employer groups that are enrolled in multiple FF-SHOPs will receive one bill per FF-SHOP. Employer groups that are participating in one or more FF-SHOPs and one or more SB-SHOPs will receive more than one bill and make more than one payment. Rates charged to employers in the FF-SHOPs will be calculated at the time of initial group enrollment and upon renewal, based on approved rates for the quarter in which initial enrollment or renewal occurs.

The FF-SHOPs will use 820 transactions to communicate information about premium payments remitted to issuers. The issuer payment process will adhere to the diagram in Exhibit 18 below.

Exhibit 18 – FF-SHOPs Issuer Payment Process



As issuers transition from the premium payment process that was in place for FF-SHOP plan years that began in 2014 (when employers paid premiums directly to issuers) to the FF-SHOP premium aggregation functionality that is available for plan years beginning in 2015 and beyond (in which all payments will be routed through the FF-SHOP system), they should keep in mind the following expectations established by CMS:

- Issuers should collect past-due balances for coverage that took effect in 2014 from employers through any delinquency processes issuers have in place for plan years that began in 2014.
- Issuers should refund credits to employers' accounts for coverage that took effect in 2014 at the end of plan years that began in 2014.

Premium Payment

Initial Group Enrollments

A full premium payment by a qualified employer to an FF-SHOP for the first coverage month of an applicable initial group enrollment is due by the 15th day of the month prior to the desired initial coverage effective date, and must be received by CMS by the 20th day of the month preceding the desired coverage effective date. This deadline helps ensure payments received as late as the 20th of the month are sufficient. It may take several days for a check to clear and qualified employers should plan accordingly. Between the 16th and the 18th days of the month prior to coverage effectuation, qualified employers will receive the notifications detailed in Exhibit 19 below if payment has not been received by the FF-SHOP.

Exhibit 19 – FF-SHOP Payment Notifications

Date	Action
16th day of the month prior to coverage effective date	First notification posted on MyAccount notifying qualified employer that payment has not been received
18th day of the month prior to coverage effective date	Phone call made by FF-SHOP Call Center and second notification posted on MyAccount notifying qualified employer that payment has not been received
26th day of the month prior to coverage effective date	Cancellation trigger is sent to the issuer

Months Following Initial Coverage Effective Date

After coverage has been effectuated, a group's monthly premium payment is due by the first day of the coverage month. Each month, the FF-SHOPs will provide each qualified employer with an invoice that identifies the employer contribution to premiums, the employee contribution to premiums, and the total amount that is due to the FF-SHOPs. The FF-SHOPs will send each participating employer a single monthly bill on or around the 10th of each month prior to the coverage month. The FF-SHOPs have a 31-day grace period for payment of premiums after coverage has taken effect. If full payment is not received 31 days from the first day of the coverage month, the FF-SHOP may terminate the qualified employer's coverage for failure to pay premiums. If payment is not received by the due date, the collection and notification process detailed in **Error! Not a valid bookmark self-reference.** below will occur.

Exhibit 20 – Collection and Notification Process

Date	Action
2nd day after payment is due	1st past due notification posted to qualified employer's MyAccount; grace period begins
10th day after payment is due	Regular monthly invoice will note any past-due amount
15th day after payment is due	2nd past due notification posted to qualified employer's MyAccount. A letter will also be mailed to the employer regardless of preferred method of communication.
20th day after payment is due	3rd past due notification posted to qualified employer's MyAccount. A courtesy phone call will be made to the qualified employer advising no payment has been received and coverage will be terminated if payment is not received before the end of the grace period. A/B associated with an employer's account will also be notified.

If a group is in its grace period, the FF-SHOPs will consider a group to be in good standing after a FF-SHOP receives 100% of the correct account balance, which in some cases might be less than the total invoice. The current account balance may be less than the invoiced amount because a terminated enrollment of an enrollee or dependent may not be reflected on the most current

invoice. Depending on applicable state law, issuers may be able to pend claims during the 31-day period after payment is due, prior to the receipt of payment from the FF-SHOP. If a group's coverage is terminated for non-payment of premium, issuers will receive a termination transaction. A termination transaction will be sent to issuers three business days after the 31 day grace period ends. The 3-day lag will ensure payment made on the last day of the grace period is sufficient.

Prorating of Premiums

In the FF-SHOPs, premiums can be prorated for partial-month enrollments, which might occur when an enrollee dies or when a child dependent is born or adopted. Pursuant to 45 CFR §155.705(b)(4)(ii)(C), premiums for coverage lasting less than one month will be prorated in the FF-SHOPs by dividing the total premium for one month of coverage by the number of days in the applicable month, then multiplying the result by the number of days in the month during which coverage is provided to the applicable enrollee or enrollees. The FF-SHOPs will charge and collect only for the portion of coverage provided for the partial month of coverage.

Examples

Example 3C: An employer receives an invoice from the FF-SHOP that does not reflect the recent termination of an employee. The employer should access the FF-SHOP portal to ensure that its current account balance is accurate and reflects the termination. The employer should pay the full current account balance to be considered in good standing with the FF-SHOP. The employer should contact the FF-SHOP Call Center if any additional assistance is required resolving this discrepancy or remitting payment.

Example 3D: An employee adopts a child and would like to add this child to his or her coverage through an FF-SHOP, with the child's coverage become effective on March 10th (date of placement for adoption). The prorated premium amount for this child's coverage is calculated by dividing the premium for one month ($350) by the number of days in the month (31), then multiplying the resulting quotient by the number of days of coverage in the partial month (22). This equation [(350/31) * 22] calculates the prorated premium for the child's partial coverage as $248.39.

Terminations for Non-Payment in FF-SHOPs and FF-SHOP Reinstatements

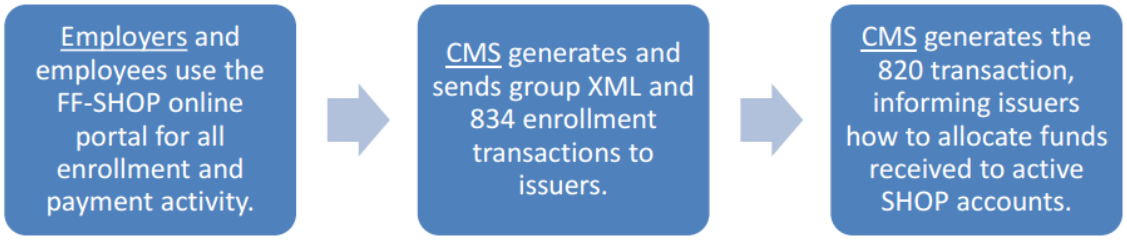
If an FF-SHOP does not receive full payment for a group within 31 days from the first day of the coverage month, the FF-SHOP may terminate the group's coverage for lack of payment. Pursuant to 45 CFR §155.735(c)(2), employers wishing to have their coverage through an FF-SHOP be reinstated following termination due to non-payment of premiums must pay all premiums owed, including any prior premiums owed for coverage during the grace period, and pre-pay the premium for the next month's coverage within 30 days following the termination. If the group pays this amount in full within the 30-day window, the FF-SHOP will send a reinstatement transaction to the affected issuer(s) and will reinstate the group in its previous coverage. A qualified employer may be reinstated in an FF-SHOP only once per calendar year.

Employers can handle this online or by contacting the FF-SHOP Call Center. Issuers may pend claims as allowed by state law when a group is in the 31-day grace period for payment of late premiums.

3.9 CONFIRMATION OF THE 834 TRANSACTION

In the FF-SHOPs, after a qualified employer completes the group enrollment process, the FF-SHOP will send a group XML and 834 enrollment transaction to issuers. Group XML files are sent immediately and 834 enrollment transactions are batched and sent at the end of each business day (Monday through Friday, except for federal holidays). Each issuer is sent a separate group XML for each qualified employer. Finally, on a weekly basis, each issuer will be sent an 820 payment transaction informing the issuer of the allocation of funds for each group enrolled in its coverage through a FF-SHOP. Exhibit 21 below depicts this process.

Exhibit 21 – XML and 834 Transaction in FF-SHOPs



For renewals of coverage effective for plan years beginning on or after January 1, 2016, issuers will receive new Group XMLs and 834s for groups renewing coverage through an FF-SHOP. A renewal indicator will not be included on the group or member transactions. The Group XML will include the Payment Transaction ID and Employer ID, both of which will remain the same for the qualified employer from Plan Year 2015 to 2016, provided that the qualified employer and/or enrollees enroll with the same issuer and there is no gap in coverage. The Group XML will also include the Issuer Assigned Group ID, when sent to FF-SHOP on effectuation transactions. The 834 will include the Exchange Assigned Member ID and Exchanged Assigned Subscriber ID, both of which will remain the same for qualified employees, other enrollees, and applicable dependents from Plan Year 2015 to 2016. The Issuer Assigned Member ID and the Issuer Assigned Subscriber ID will also be included on renewal 834s, when available.

Issuer Assigned IDs (from the 834 effectuation file) and Insurance Policy Group IDs (from the Group XML) will be included if the enrollee enrolls with the same issuer as the prior year and there is no gap in coverage. The 5-digit HIOS ID will be used to identify that it is the same issuer as the prior year.

3.10 CANCELLATIONS IN THE FF-SHOPS

Overview

A cancellation can include a transaction withdrawing a plan selection for health insurance coverage before the effective date of coverage. Cancellations in the FF-SHOPs can be initiated by a qualified employer or a qualified employee, or by an FF-SHOP. Cancellations of coverage in the FF-SHOPs may not be initiated by issuers.

A qualified employer or qualified employee may, before the effective date of coverage, 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-SHOPs. Employers and employees should complete submission of a cancellation request to a FF-SHOP by 11:59 p.m. ET on the date prior to the coverage effective date. CMS will send a cancellation Group XML and 834 transaction to affected issuers after an employer or qualified employee cancels coverage.

Example

Example 3E: A qualified employer has already remitted payment for its initial group enrollment when a qualified employee notifies the employer that the qualified employee would like to cancel the qualified employee's acceptance of the offer of coverage. The qualified employer submits a cancellation transaction to the FF-SHOP by 11:59 p.m. ET on the date prior to the coverage effective date. Qualified employees can also initiate the cancellation. The payment submitted by the employer for the qualified employee whose coverage was cancelled will be reflected as a credit on the employer's next monthly invoice and (if the payment was already routed to the issuer) on the issuer's next 820 transaction.

3.11 TERMINATIONS

A termination is an end of an enrollee's coverage or enrollment in a QHP/QDP through the FF-SHOPs occurring after their coverage effective date. A termination may be either voluntary (i.e., initiated by the enrollee or the employer) or involuntary (i.e., initiated by the FF-SHOPs).

3.11.1 Group-Level Terminations in the FF-SHOPs

When an employer requests that the entire group's enrollment or coverage be terminated, the termination may be effective only on the last day of any month. The employer must make the request no later than the 15th of the month in which the employer wants the termination to be effective. A request that the entire group be terminated that is submitted after the 15th of the month will not be effective until the last day of the following month.

Beginning January 1, 2016, the FF-SHOPs will be responsible for sending termination notices related to terminations for loss of eligibility or non-payment of premiums to both qualified employers and enrollees. This relieves issuers of this requirement, except where state law requires a QHP issuer to send these notices. If state law requires issuers to send these notices, the

issuer is still responsible for sending these notices. If not required to do so by state law, issuers may also send these notices if desired, but the fact that the issuer has sent a notice does not exempt an FF-SHOP from the notice requirement. The FF-SHOPs will also send a notice to employers confirming termination of the group's enrollment through the FF-SHOP if the employer has withdrawn its participation in the FF-SHOP (including when it has decided not to renew its participation in the FF-SHOP).

The FF-SHOPs will not send a termination notice to an issuer if an employer renews its SHOP participation but does not renew with that particular issuer. Similarly, the FF-SHOPs will not send an issuer a termination notice when an enrollee renews SHOP coverage but does not renew coverage with that issuer.

3.11.2 Enrollee-Level Terminations in the FF-SHOPs

A qualified employee or qualified employer may voluntarily request termination of coverage and/or enrollment for a qualified employee or dependent through the FF-SHOP. However, unless the enrollee has an SEP, the FF-SHOP system can terminate coverage or enrollment for an enrollee or remove the enrollee from the roster mid-plan year only if the request is submitted by the qualified employer. The system can process a request from a qualified employee to initiate a mid-plan year termination for the individual and/or his or her dependents only when the individual and/or his or her dependents qualify for an SEP. Enrollee-level terminations are effective on the last day of the month in which the FF-SHOP receives notice of the requested termination and notice must have been received by the FF-SHOP prior to the proposed date of termination. Pursuant to 45 CFR §155.720(h), if any employee terminates coverage from a QHP, the SHOP must notify the employee's employer.

During an SEP, a qualified employee requesting to terminate coverage may do so by any of the following methods:

1. Logging on to MyAccount and taking action in response to the SEP.
2. Contacting the FF-SHOP Call Center at 1-800-706-7893 (TTY: 711).
3. Contacting an FF-SHOP registered A/B associated with the qualified employer's account, or having a Navigator, non-Navigator assistance personnel, or certified application counselor assist the qualified employee by walking the qualified employee through the online process with the qualified employee logged into their MyAccount to respond to the SEP.

Beginning January 1, 2016, the FF-SHOPs will be responsible for sending termination notices to enrollees if the enrollee:

1. Has become ineligible to enroll in coverage through the FF-SHOP because the employer is no longer offering coverage through the FF-SHOP (including if the employer withdrew from the FF-SHOP or decided not to renew FF-SHOP participation) or because the employer is ineligible to offer coverage through the FF-SHOP
2. Has enrollment through the FF-SHOP terminated due to non-payment of premiums

Examples

Example 3F: An employer decides to voluntarily terminate his or her participation in an FF-SHOP. The employer submits a termination request on the 14th day of the month in which the employer wants the termination to be effective. Enrollment through the FF-SHOP will terminate for the entire group on the last day of the month. Beginning January 1, 2016, the FF-SHOPs are responsible for sending a notice of termination to enrollees. The notice of termination to enrollees includes: information about the enrollee and applicable dependents, including the name of the plan(s) in which the enrollee and any applicable dependents were enrolled; the date the termination will be effective; the reason for termination; and whether the termination of enrollment through the FF-SHOP will lead to a termination of coverage and the consequences of termination.

3.11.3 Dependent Age-offs in the FF-SHOPs

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 must continue to make such coverage available for an adult child until the child turns 26 years of age. However, states have varying rules on the maximum dependent age-off. Information on specific state rules must be obtained directly from a state's DOI.

If an employer offers dependent child coverage through an FF-SHOP, and a dependent is approaching the maximum child dependent age for the plan, the FF-SHOPs will send a notice 90 days in advance of the age-off. This advance notice is sent to alert the enrollee that the dependent is reaching the maximum child dependent age for the plan. The notice will include the date the dependent will reach the maximum child dependent age for the plan and information about next steps. The actual termination notice will be sent after the dependent ages off and no longer has dependent coverage through an FF-SHOP (including any applicable continuation coverage offered through an FF-SHOP).

3.12 RENEWALS IN THE FF-SHOPS

Currently, for operational reasons, renewal of FF-SHOP participation and/or coverage is not an automated process and requires both qualified employers and qualified employees to access their accounts on HealthCare.gov. The FF-SHOP renewal process applies to employer groups that were determined eligible to buy coverage through an FF-SHOP and had qualified employees enroll in a plan through the FF-SHOP in the previous plan year. While the FF-SHOPs will send notices about the renewal process to employer groups and employees, this does not relieve issuers of their renewal notice requirements. For information on issuer requirements involving renewal notices, see guidance published by CMS on September 2, 2014, available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Renewal-Notices-9-3-14-FINAL.PDF.

For plan years beginning on or after January 1, 2016, medical and dental coverage renewals will be considered separately so that a qualified employee (and dependents, if applicable) may renew medical coverage alone, dental coverage alone, or both, provided that the qualified employer continues to offer both medical and dental coverage through the FF-SHOP.

Renewals for Employers

An employer may decide to renew its FF-SHOP participation as well as the coverage it offered in the previous year through the FF-SHOPs. The employer may also decide that it will renew its FF-SHOP participation, but not renew the coverage it offered in the previous year through the FF-SHOPs. Both of these circumstances are considered renewals of FF-SHOP participation and must follow the FF-SHOP renewal process, even when they do not result in an issuer's renewing coverage, as defined for purposes of guaranteed renewability.

For plan years that began in 2014, enrollment through the FF-SHOPs took place directly with issuers. Employers are considered to be qualified employers in a FF-SHOP if they:

- Filed an FF-SHOP employer eligibility application in late 2013 or in 2014,
- Were notified by an FF-SHOP in late 2013 or in 2014 that they were eligible to participate in the FF-SHOP, and
- Purchased an FF-SHOP-certified QHP directly from a health insurance issuer in late 2013 or in 2014, before FF-SHOP online functionality was available.

CMS regulations at 45 CFR §155.725 require the FF-SHOPs to set a standard annual employer election period for renewing FF-SHOP employers and to set a standardized annual open enrollment period for renewing qualified employees. Qualified employers will be able to renew their offer of coverage through an FF-SHOP electronically through HealthCare.gov as soon as plan and rate information becomes available for the quarter in which their coverage would end, but generally not more than two months before the date an enrollment must be submitted to avoid a gap in coverage: this is when the annual election period begins for that employer.

Employers renewing SHOP coverage that will take effect during the first quarter of calendar year 2016 will be able to view rates and begin the renewal process as early as November 1, 2015. Qualified employers renewing an offer of coverage in an FF-SHOP must provide their qualified employees with an annual open enrollment period of at least one week to decide whether to accept the coverage offer. This one-week minimum period is the qualified employees' annual open enrollment period. Consistent with 155.725(h)(2), both the qualified employer and qualified employee renewal process must be completed by 11:59pm ET on the 15th day of the month preceding the desired renewal date for it to take effect by that date. The employer's election period should therefore end at least one week prior to the deadline for completing a renewal that would take effect at the end of the employer's prior plan year.

For example, an employer group whose plan year ends on December 31, 2015, and who is seeking a coverage renewal date of January 1, 2016, must complete the renewal process by December 15, 2015. This employer's election period begins when the plan and rate information

for the first quarter of 2016 becomes available, which CMS expects to be November 1, 2015. The employer's election period must end by December 7, 2015, to give qualified employees at least one week to make decisions about the employer's coverage offer. In the Notice of Annual Election Period, which CMS expects to begin sending to renewing employers by November 1, 2015, the FF-SHOPs will remind qualified employers to provide qualified employees with an open enrollment period of this length; the employer should ensure that its employees have at least the one week period from December 8, 2015, through December 15, 2015 (or the applicable dates for a given employer), to respond to the employer's offer.

The FF-SHOP online system is not able to distinguish between an employer renewing its 2014 participation in a FF-SHOP; and an employer completing an initial group enrollment for coverage taking effect in 2015 or beyond. As a result, when they go into the online system for the first time, qualified employers renewing their 2014 participation in a FF-SHOP are asked to answer the same questions and make the same attestations regarding their FF-SHOP eligibility that they did on the paper application they completed for coverage that took effect in 2014. These employers should answer these questions based on information applicable to the year for which they will be renewing, with one important exception. CMS regulations, at 45 CFR §155.710(d), require that the FF-SHOPs treat a qualified employer offering SHOP coverage that ceases to be a small employer solely by reason of an increase in the number of employees, as eligible to participate in the SHOP until the employer otherwise fails to meet FF-SHOP eligibility criteria or no longer purchases coverage for qualified employees through the SHOP. Therefore, if the employer was a small employer when it began participating in the FF-SHOPs in 2014 and offered coverage through SHOP in 2014, it should attest to its size based on its 2014 attestation, even if it now has grown such that it no longer meets the definition of "small employer" in 45 CFR §155.20. Employers renewing participation for plan years beginning on or after January 1, 2016, will not have to go through the eligibility process again.

Generally, once employers have been determined eligible for coverage through a FF-SHOP, they remain eligible unless there are any changes to the location through which they offer coverage, or any changes to whether they offer coverage to all full-time employees.

To renew FF-SHOP participation that began after November 15, 2014, when the online system became available, employers will need to log in to HealthCare.gov. Personalized notices regarding the annual employer election period and the opportunity to renew or change employer participation in the SHOP will be sent automatically to the user's MyAccount at HealthCare.gov before the election period begins. The electronic FF-SHOP Annual Employer Election Period notice will include information about potential actions employers may want to take to renew previous coverage choices, modify previous coverage choices or contributions to employee premiums, or terminate FF-SHOP participation. The notice includes information about the date the current plan year is ending as well as the first date the employer can opt to renew its coverage offer and the date by which the annual election period will end. Issuers are not responsible for distributing these notices, but are still subject to market-wide requirements regarding notices under 45 CFR §147.106.

Exhibit 22 – Employer Attestations in FF-SHOPs

Attestation	Explanation
To principal business address or eligible employee worksite	One of these must fall within an FF-SHOP service area
To having at least one employee	Employer must have at least one employee
To offer coverage to all full-time employees	Employer must offer coverage to all full-time employees
To having on average from 1 to 50 full-time and full-time equivalent employees on business days during the preceding calendar year – for plan years beginning before January 1, 201611	Employers must have on average from 1 to 50 full-time and full-time equivalent employees on business days during the preceding calendar year– for plan years beginning before January 1, 2016
To having on average from 1 to 100 full-time and full-time equivalent employees on business days during the preceding calendar year– for plan years beginning on or after January 1, 2016	Employers must have on average from 1 to 100 full-time and full-time equivalent employees on business days during the preceding calendar year for plan years beginning on or after January 1, 2016

Groups whose enrollment and/or coverage through the FF-SHOP has been terminated for non-payment of premium but that are still within their 30-day reinstatement window will not be able to renew FF-SHOP participation through the online system until their prior coverage has been reinstated. If the group's prior coverage is reinstated, CMS does not consider this a gap in SHOP coverage. Groups that are in a grace period for non-payment of premium will be able to renew their coverage through the online system, but will need to pay all premiums owed prior to the start of the new plan year. Groups will also need to pay the first month's premium for their new plan year before the start of the new plan year. Payments sent by existing groups at the time of renewal will be applied to current year invoices before they are applied to the new plan year.

[11] If the employer was not in existence throughout the preceding calendar year, the determination of whether the employer has the requisite number of employees shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. See ACA §1304(b), 45 CFR §155.20 (definition of "small employer"), and 45 CFR §155.710(b) and (d). This attestation and the attestation in the next row do not apply if the qualified employer has previously been determined eligible to participate in an FF-SHOP, and has since grown to no longer meet the definition of a small employer because of an increase in the number of the employer's employees, provided that the employer continues to meet all other FF-SHOP eligibility requirements and continues participating in an FF-SHOP.

Issuers are expected to effectuate new plan year coverage if they do not receive a cancellation transaction by the 26th of the month prior to the renewal coverage effective date.

Renewal for Qualified Employees

Qualified employees wishing to renew FF-SHOP participation that began in 2014 must navigate to HealthCare.gov to respond to a qualified employer's renewed offer of coverage. Since the FF-SHOP system will not be able to distinguish a qualified employee who is renewing FF-SHOP participation that began in 2014 from a newly enrolling qualified employee, a qualified employee renewing coverage that began in 2014 and that was enrolled in directly with an issuer will have to complete the FF-SHOP employee application, regardless of whether there is any change in his or her eligibility.

For plan years beginning on or after January 1, 2016, for qualified employees that submitted an electronic FF-SHOP application for coverage that began on or after January 1, 2015, some information inputted into the system for the previous plan year will be pre-populated in the employee's electronic application. Generally, as long as a qualified employer extends an offer of coverage to an employee or former employee, the employee or former employee is eligible.

Qualified employees should wait until they receive notice of the employer's renewed offer of coverage through an FF-SHOP to begin the renewal process. To renew FF-SHOP participation that began after the online system became available, qualified employees should log in to HealthCare.gov and renew coverage online. Personalized notices regarding the annual employee open enrollment period will be sent automatically to the employee's MyAccount at HealthCare.gov within the Employee portal, beginning November 1, 2015. The notice will contain information about:

- The last day of the current plan year,
- The qualified employee's enrollment period start and end dates,
- The date by which the employee needs to make coverage decisions to prevent a gap in coverage,
- How employees can learn more about the offer of coverage for the next plan year,
- How to waive or accept coverage, and
- Potential actions qualified employees may want to take to renew previous coverage choices, modify previous coverage choices, or terminate FF-SHOP participation.

When renewing coverage, qualified employers must provide their qualified employees with an annual open enrollment period of at least one week to decide whether to accept the coverage offer. The employer may provide additional time; however, all qualified employee enrollments must be finalized consistent with the timeframes under 45 CFR §155.725(h)(2), and the renewal process for the entire group must be completed by the 15th of a month for coverage to start the first day of the next month. For example, for coverage that ends December 31, 2015, the renewal process must be completed by December 15, 2015, to avoid a coverage gap.

Qualified employees will not be able to make changes to SSN, DOB, gender, and name for themselves or their dependents as part of the renewal process. These changes can be made by qualified employers contacting the FF-SHOP Call Center. Issuers will receive maintenance transactions for these changes. Changes to enrollee contact information can be made as part of the qualified employee's renewal process. These changes will be sent on renewal transactions.

Examples

Example 3G: An employer who was determined eligible to buy coverage through an FF-SHOP and had qualified employees enroll through the FF-SHOP would like to renew its 2014 FF-SHOP participation. The group's plan year ends on March 31, 2015. Since FF-SHOP participation can be renewed only after rate and plan information becomes available for the quarter in which the prior plan year would end, but generally not more than two months before the date an enrollment must be submitted to avoid a gap in coverage, the employer in this example can renew its offer of coverage as early as February 16, 2015. The employer must provide its qualified employees with at least one week to decide whether to accept the offer of coverage. The entire renewal process will take place online through HealthCare.gov. The employer should complete the employer application online and submit an employee roster through HealthCare.gov, because the initial enrollment did not take place through the online FF-SHOP system. The employer's qualified employees should also create accounts and make coverage decisions online at HealthCare.gov. In this example, the employer group must submit its completed renewal online by March 15, 2015, to have coverage take effect on April 1, 2015, with no gap in coverage.

Example 3H: Qualified employees receive a renewed offer of coverage from a qualified employer and are given two weeks to respond. The FF-SHOP does not receive a response to the renewed offer of coverage from a qualified employee in a timely manner. As a result, the qualified employee will not be enrolled when the group's renewal is processed. For the qualified employee to avoid a gap in coverage, the qualified employee must go online to HealthCare.gov and respond to the renewed offer of coverage during the annual employee open enrollment period set by the qualified employer.

3.13 FF-SHOP REQUIRED NOTICES

The FF-SHOP will be issuing notices to employers and employees as required under 45 CFR §155(H) in relation to their participation in the FF-SHOPs. Exhibit 23 below details the various types of required notices.

Exhibit 23 – FF-SHOP Required Notices (Other than Notices Related to Appeals)

FF-SHOP Required Notices
FF-SHOP Required Notices to Employers
Employer Eligibility Determination Notice (45 CFR §155.715(e)) – Sent after the processing of an initial application. Includes notice of right to appeal.

FF-SHOP Required Notices
Notice of Annual Employer Election Period (45 CFR §155.725(d)) – Includes information on the date the current plan year is ending, the first date an employer can opt to renew coverage, and the date by which the annual election period will end.
Notice of Employee Termination (45 CFR §155.720(h)) – Notification to the employer of an employee's termination of coverage. Includes effective date of termination.
Notice of Employer Termination of Coverage and/or Enrollment (45 CFR §155.735(g)) – Notification to the employer of termination of the employer group's coverage and/or enrollment through the FF-SHOP due to loss of eligibility or non-payment of premiums. If state law requires issuers to send these notices, the FF-SHOP is not required to send the notice. (Beginning January 1, 2016)
FF-SHOP Required Notices to Qualified Employees and Enrollees
Employee Eligibility Determination Notice (45 CFR §155.715(f)) – Sent after the processing of an initial application. Includes notice of right to appeal.
Notice of Employer Withdrawal (45 CFR §155.715(g)) – Notification to qualified employees of their employer's withdrawal of participation in an FF-SHOP. Includes information regarding other potential sources of coverage, including access to individual market coverage through the Marketplaces.
Notice of Annual Employee Open Enrollment Period (45 CFR §155.725(f)) – Includes information on current coverage, date the current plan year is ending, dates that an employee's annual open enrollment period starts and ends, and more information about the coverage being offered, including how to accept or waive the offer.
Notice of Enrollee Termination of Coverage and/or Enrollment (45 CFR §155.735(g)) – Notification to an enrollee of termination of coverage and/or enrollment through an FF-SHOP due to loss of the enrollee's eligibility to participate in the FF-SHOP or non-payment of premiums. Loss of an enrollee's eligibility includes an enrollee who loses eligibility because a qualified employer has lost its eligibility. If state law requires issuers to send these notices, the FF-SHOP is not required to send the notice (beginning January 1, 2016).
Qualified Employer Required Notices to Qualified Employees
Notice of Enrollment Process (45 CFR §157.205(c) and (e)) – A qualified employer must inform each qualified employee (including employees who are hired outside of the initial and annual open enrollment periods for the employer group) that he or she is being offered coverage through an FF-SHOP. Employers must include instructions about how to enroll in health insurance coverage through an FF-SHOP, and should include information about what formats the employee may use to submit an application (i.e., online, or by phone). If the qualified employee being offered coverage was hired outside of an initial or annual enrollment period, the notice will include information about the enrollment process, including the enrollment period for newly qualified employees pursuant to 45 CFR §155.725(g).

FF-SHOP Required Notices
Qualified Employer Required Notices to FF-SHOPs
Notice of Change in Eligibility for Coverage (45 CFR §157.205(f)) – A qualified employer must provide an FF-SHOP with information about dependents or employees whose eligibility status for coverage purchased through the employer in the FF-SHOP has changed, including newly eligible dependents and employees, and loss of qualified employee status. Information submission may be completed online or by phone.

4. DIRECT ENROLLMENT (APPLICABLE TO INDIVIDUAL MARKET FFMS, QHP/QDP)

Currently, direct enrollment is available only in the individual market FFMs and is not available in FF-SHOPs.

The direct enrollment process allows new applicants and existing enrollees (either directly or through an FFM-registered A/B) to enroll in a QHP in a manner considered to be through the FFM during an OEP or SEP, when the process is originated through either a QHP issuer website or web-broker website (referred to as an Enrollment Partner website). Enrollees also have the ability to report a life change through direct enrollment.

The FFMs have made available an Application Programming Interface (API) that allows an Enrollment Partner to submit enrollment requests to the FFMs through a web service invocation. Enrollment requests are processed by the FFMs and sent to the QHP issuer via an 834 transaction. Enrollment Partners using the direct enrollment model should adhere to the guidelines outlined in the "FFM Direct Enrollment API for Web-brokers/Issuers Technical Specifications." The FFM direct enrollment API provides Enrollment Partner websites access to the FFMs' eligibility and enrollment business services through a combination of secure transfers whereby the applicant or applicant's FFM-registered A/B is redirected to and from the FFM's website and utilizes the FFMs' web services. The secure transfer of the applicant or applicant's FFM-registered A/B from the Enrollment Partner website to the FFMs' is used for submission of the eligibility application (for initial eligibility determinations, as well as eligibility redeterminations for a new plan year or change within a plan year).

Upon receiving an eligibility determination, the applicant or applicant's FFM-registered A/B is securely transferred back to the Enrollment Partner website where they can compare and select a QHP, utilizing the eligibility information provided by the FFM, and submit the enrollment request to the FFM for that applicant. The plan shopping experience, including submission of the plan selection and amount of APTCs selected (for those who are eligible), is implemented by the Enrollment Partner website using its own shopping and rating tools. Exhibit 24 illustrates the process flow for an applicant shopping for QHPs through direct enrollment. Exhibit 25 illustrates the process flow for a new applicant's FFM-registered A/B assisting the consumer using direct enrollment.

Exhibit 24 – New FFM Applicant Using Direct Enrollment

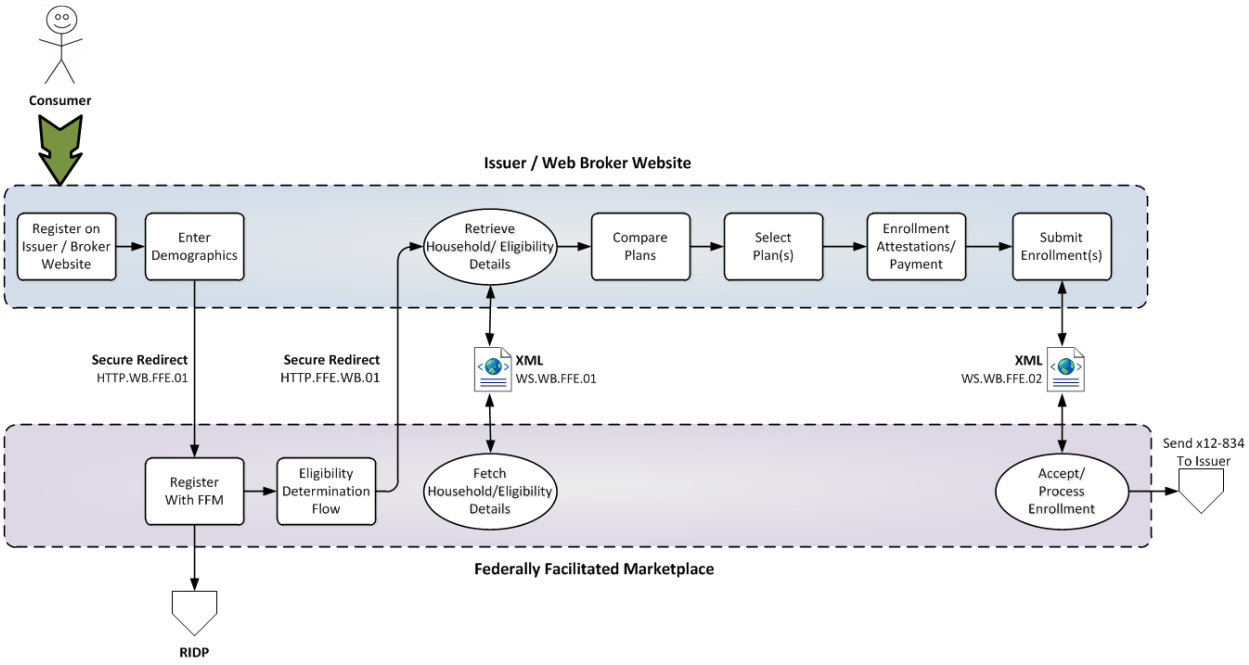
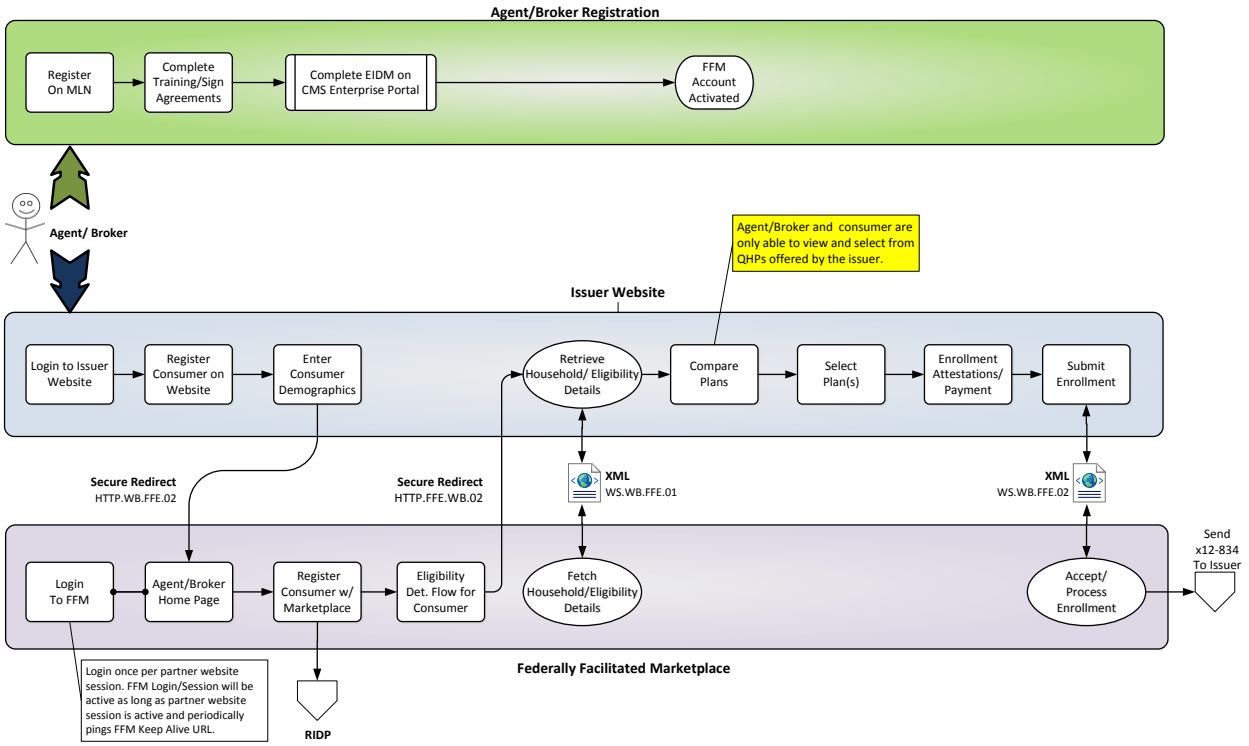


Exhibit 25 – New Applicant's FFM-Registered A/B Using Direct Enrollment



4.1 ADDITIONAL INTERACTIVE SCENARIOS

For a comprehensive list of scenarios and process flows/technical specifications including returning FFM applicants, applicants reporting life changes, and applicants found eligible for public programs, such as Medicaid/CHIP, please refer to the "FFM Direct Enrollment API for Web-brokers/Issuers Technical Specifications" located on CMS zONE, https://zone.cms.gov/. Enrollment Partners that wish to access CMS zONE may send their requests to Calt_Support@cms.hhs.gov.

The direct enrollment API currently supports any new enrollees, as well as individuals with existing coverage through the FFMs who want to switch QHPs during an OEP or SEP, if applicable. The API also allows an enrollee to report a life change through direct enrollment. Existing enrollees who want to obtain an updated eligibility determination and/or select the same plan or a new plan during open enrollment can do so by selecting a pre-populated application with information from their application for the previous plan year and updated information obtained by the FFM. Please refer to Sections 2.8, Redeterminations and Renewals, for information on redeterminations and renewals. Existing enrollees who have submitted an application and want to report a change during the plan year may also do so by selecting their current year application and making the appropriate changes. If the change results in the individual being eligible for an SEP, the enrollee may return to the Enrollment Partner website to select the same or new QHP, including updating financial assistance amounts.

Enrollees will also be able to switch QHPs using direct enrollment throughout an OEP and during an SEP, if applicable. Furthermore, for enrollees who wish to switch QHPs during an OEP or an SEP, the FFMs will give enrollees the choice to either return to the Enrollment Partner's website or stay on the FFM website. This is the only situation when an enrollee coming in through the consumer direct enrollment pathway will have the ability to stay on the FFM website as opposed to being redirect back to the Enrollment Partner website. Please note that this option to stay on the FFM website when switching plans is only available for the consumer flow for direct enrollment. FFM-registered A/Bs will not be given that option and will only be able to return to the Enrollment Partner website. Please note that consumers and FFM-registered A/Bs will be redirected back to the Enrollment Partner website when first selecting a QHP during an OEP or an SEP. It is only after a selection is made during an OEP or SEP, that a consumer will have an option to switch QHPs, if eligible.

4.2 GUIDELINES FOR SPECIFIC QI SCENARIOS

The FFMs provide eligibility results for all individuals seeking coverage on the application as part of the household/eligibility web services response. The FFMs also provide 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, the FFMs will make a determination of eligibility for APTCs and CSRs and an assessment or determination of eligibility for Medicaid and/or CHIP, depending on the state's election.

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 (or applicant's FFM-registered A/B) at HealthCare.gov. This information is retrieved by the Enrollment Partner as part of the fetch eligibility web services response. The applicant (or applicant's FFM-registered A/B) is transferred back to the Enrollment Partner website, and the applicant can view and select a plan offered outside the FFMs, if desired.

Applicant is Eligible for QHP Enrollment and APTCs/CSRs

If an applicant is found eligible for enrollment in a QHP through the FFM and is determined eligible for APTCs or CSRs, the FFM provides this information to the applicant (or applicant's FFM-registered A/B) at HealthCare.gov, and the Enrollment Partner retrieves this information as part of the fetch eligibility web services response. The FFM transfers the applicant (or applicant's FFM-registered A/B) back to the Enrollment Partner website to select a QHP. The Enrollment Partner must allow applicants to select the amount of APTCs they want to apply towards the reduction of their share of the premiums in the plan selection process, and should only display the CSRs plan variation for which an applicant is found eligible, for any of the QHP issuer's silver-level plans (or American Indian/Alaskan Native CSRs variations, as appropriate).

Applicant is Eligible for QHP Enrollment but Not for APTCs/CSRs

If an applicant is found eligible for enrollment in a QHP through the FFM, but is not determined eligible for APTCs or CSRs, the FFM provides this information to the applicant (or applicant's FFM-registered A/B) at HealthCare.gov, and the Enrollment Partner retrieves this information as part of the fetch eligibility web services response. The FFM transfers the applicant (or applicant's FFM-registered A/B) back to the Enrollment Partner website to select a QHP. In the plan selection process, the Enrollment Partner should not include any APTCs amounts for an applicant who is not eligible for APTCs, or CSRs plan variations for an applicant who is not eligible for CSRs.

Applicant is Eligible for Medicaid or CHIP

If an applicant is assessed or determined eligible for Medicaid or CHIP, the FFM sends the applicant's information to the appropriate state Medicaid or CHIP agency and informs the applicant (or applicant's FFM-registered A/B) that the state agency will follow-up with the applicant, or the applicant may contact the relevant state agency regarding their status.

Medicaid/CHIP MAGI Eligibility Scenario: If an applicant is determined eligible or assessed as potentially eligible for Medicaid/CHIP based on MAGI, his or her account is transferred to the state Medicaid/CHIP agency. The Enrollment Partner retrieves the eligibility information as part of the fetch eligibility web services response. The Enrollment Partner should not include those eligible for Medicaid or CHIP in an enrollment group because the Enrollment Partner would receive an error since the system can only accept a submitted enrollment response for applicants

that are marked as eligible for a QHP in the fetch eligibility web service. There is a system limitation that will show an applicant as ineligible for a QHP on the fetch eligibility web service if they are Medicaid/CHIP eligible. Most of these applicants would be eligible to enroll in QHPs through the Marketplace, without APTCs or CSRs, but they must come back to the Marketplace to enroll in QHPs.

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

Medicaid/CHIP Non-MAGI Eligibility Scenario: The FFM will also screen for eligibility for Medicaid based on factors other than MAGI (e.g., disability, long-term care needed) and allow applicants to request an eligibility determination on these bases. If an applicant indicates on the application that they are disabled or have a long-term care need, but they also have been determined eligible for enrollment in a QHP through the Marketplace, the FFM will transfer the applicant to the Enrollment Partner website and indicate that the applicant is eligible to select a QHP through the Marketplace (if the applicant wants to select a QHP pending the outcome of the non-MAGI Medicaid eligibility determination), and the Enrollment Partner will retrieve the eligibility information as part of the fetch eligibility web services response. If the applicant is eligible for APTCs or CSRs pending the outcome of the non-MAGI determination, the amount of APTCs or CSRs available will be provided by the FFM as part of the fetch eligibility web services response and should be used during the plan selection process.

Households That Include Individuals Eligible for Different Coverage Programs

For households that include individuals eligible for different coverage programs (e.g., QHP with APTCs, Medicaid), Enrollment Partners 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. Enrollment Partners should not include any applicants in the QHP selection process who are not listed as eligible for enrollment in a QHP through the Marketplace in the information received through the fetch eligibility web services response because the Enrollment Partner would receive an error since the system can only accept a submit enrollment response for applicants that are marked as eligible for a QHP in the fetch eligibility web service. There is a system limitation that will show an applicant as ineligible for a QHP on the fetch eligibility web service if they are Medicaid/CHIP eligible. Most of these applicants would be eligible to enroll in QHPs through the Marketplace, without APTCs or CSRs, but they must come back to the Marketplace to enroll in QHPs.

Enrollment Partners have the ability to create their own shopping experience once an applicant is directed to the Enrollment Partner's website. Nevertheless, if a household has applicants who are determined eligible for QHP enrollment through the FFM and others who are not eligible, the Enrollment Partner website must first complete the plan selection process for applicants eligible for QHP enrollment through the FFM prior to completing the plan selection process for individuals who are not eligible for QHP enrollment through the FFM. While the Enrollment Partner may not enroll applicants in Marketplace coverage who are not determined eligible for QHPs, they may enroll them in coverage outside the Marketplace after handling those applicants who are QHP eligible.

4.3 ENROLLMENT GROUPS

Due to system limitations, direct enrollment for applicants applying for financial assistance through an FFM is currently limited to enrollment groups consisting of a single tax household (that is, only applicants who are included on the same tax return are able to enroll together in a QHP through the Marketplace). Furthermore, due to system limitations, direct enrollment cannot handle applicants seeking to enroll in a catastrophic health plan. However, direct enrollment accommodates enrollment in QHPs through the FFMs for enrollment groups that include multiple tax households, only as long as applicants are not seeking financial assistance.

If a group of applicants applying for financial assistance through an FFM starts at an Enrollment Partner website, completes the eligibility application at HealthCare.gov for multiple applicants, and the applicants are identified as having multiple tax households, the applicants will complete the application process and will be able to return to the Enrollment Partner website. However, the FFMs will indicate in the eligibility response that there is more than one tax household included in the application, and the Enrollment Partner will need to direct the applicants to the FFM website to select QHPs (for financial assistance applications).

If an applicant is redirected to an Enrollment Partner website, the Enrollment Partner website should continue to use an issuer's current subscriber-dependent rules when determining who can be placed in a policy together. Enrollment Partner websites that are capable of supporting multiple enrollment groups should give QIs 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 APTCs for multiple enrollment groups. If an Enrollment Partner website is unable to support multiple enrollment groups, it should make the applicant aware that they can access this functionality at HealthCare.gov as described in the disclaimer below.

It is important to note that all QIs on a single application may only enroll using direct enrollment if doing so at the same time with a single Enrollment Partner. A QI cannot go to Enrollment Partner A's website and enroll some of the tax household and then go to Enrollment Partner B's website to enroll the remaining QIs. The submit enrollment request must include all policies for the application, and the Enrollment Partner should not send multiple enrollment requests as this will cause an error.

Additionally, due to operational limitations, QIs need to select QHPs prior to selecting QDPs. Enrollment Partners who only offer dental coverage are not permitted at this time to participate in direct enrollment. Applicants that want to enroll in a QDP via direct enrollment may do so after making a QHP selection. QHP issuer Enrollment Partners that do not offer dental should include this information in the HHS-approved universal QHP issuer disclaimer described in Section 4.5, Mandatory Attestations.

4.4 QHP DISPLAY GUIDANCE

QHP Issuer Enrollment Partner

Enrollment Partners that plan to use direct enrollment must adhere to CMS requirements with respect to the display of QHP information. Different regulatory requirements extend to the Enrollment Partner websites depending on whether they are QHP issuer websites or web-broker websites. Details on each follow.

The QHP issuer Enrollment Partner website:

1. Must, in accordance with 45 CFR §156.1230(a)(1)(ii) and 155.205(b)(1), provide applicants the ability to view QHPs offered by the issuer with the standardized comparative information on each available QHP, to the extent such information is currently required to be available:
    a. Premium and cost-sharing information (total and net premium based on APTCs and CSRs)
    b. Summary of benefits and coverage
    c. Identification of whether the QHP is a bronze, silver, gold, or platinum level plan, or a catastrophic plan
    d. Provider directory
    e. The results of an enrollee satisfaction survey
    f. Quality ratings
    g. Medical loss ratio information
    h. 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 (e.g., vision, or accident) alongside QHPs. QHP issuer Enrollment Partners should provide applicants the ability to search for off-Marketplace products in a separate section of the website other than the QHP webpages; such plans may be marketed and displayed after the QHP selection process has been completed. However, the QHP issuer Enrollment Partner website must clearly distinguish between QHPs for which the QI is eligible and other non-QHPs that the QHP issuer may offer, and indicate that APTCs and CSRs apply only to QHPs offered through the FFMs as set forth in 45 CFR §156.1230(a)(1)(iii).
3. Should provide filters for searching through plan options on QHP issuer Enrollment Partner's QHP websites, which may include, but are not limited to:
    a. All plans
    b. Premium

   c. Deductible
   d. Maximum out-of-pocket cost
   e. Plan type (e.g., HMO, PPO)
   f. Dental coverage included
   g. 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, QHP issuer Enrollment Partners should only display the CSRs plan variation that an individual is found eligible for, any of the QHP issuer's second lowest cost silver-level plans, or American Indian/Alaskan Native CSRs variations as appropriate.
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 Enrollment Partner websites must ensure that the premiums charged to an applicant are the same as the amount the FFMs would have calculated had the applicant selected a QHP via the FFMs. It is important to note that the QHP issuer Enrollment Partner is responsible for collecting information on the tobacco status for each applicant and should factor that in when calculating each enrollee's rate. Currently, the FFMs are only able to support changes in enrollees' tobacco status during open enrollment or an SEP as part of the enrollment XML file provided from issuers to the FFMs. QHP issuer Enrollment Partners should refer to the other sections of this manual and the "FFM Direct Enrollment API for Web Brokers/Issuers Technical Specifications" to ensure that they are correctly rating and applying the correct financial amounts for an enrollee based on their situation (new vs. existing enrollee making a mid-year change, effective date first of the month vs. mid-month, etc.).

QHP issuer Enrollment Partners must provide an HHS-approved disclaimer as set forth in 45 CFR §156.1230(a)(1)(iv). QHP issuer Enrollment Partners must make this disclaimer available to all applicants regardless of how applicants communicate with the QHP issuer (e.g., through a website, by phone, in-person). The FFMs expect that QHP issuer Enrollment Partners will make this available at the beginning of the plan comparison process, and if an applicant is using a QHP issuer's website, the QHP issuer must prominently display this disclaimer when displaying plans to the applicant. The disclaimer must read:[12]

"Attention: This website is operated by [Name of Company] and is not the Health Insurance Marketplace website at HealthCare.gov. This website **does not** display all Qualified Health Plans

[12] 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.

available through HealthCare.gov. To see all available Qualified Health Plan options, go to the Health Insurance Marketplace website at HealthCare.gov.

Also, you should visit the Health Insurance Marketplace website at HealthCare.gov if:

1. You want to select a catastrophic health plan.
2. You are applying for financial assistance through the Marketplace and 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 offered by a different issuer that covers pediatric dental services or a separate dental plan with pediatric coverage.]"

The QHP issuer Enrollment Partner should observe the following guidelines for displaying the disclaimer:

- Display the disclaimer prominently so it is noticeable to the applicant in the context of the website. The Enrollment Partner may change the font color, size or graphic context of the disclaimer to accomplish this. For example, the Enrollment Partner 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 Enrollment Partner maintains screens for on its website.

Web-broker Enrollment Partner

Web-broker Enrollment Partner websites must—in accordance with 45 CFR §155.220(c)(3)(i)—disclose and display all QHP standardized comparative information provided by the Marketplace consistent with the requirements of 45 CFR §155.205(b)(1) and §155.205(c) for all QHPs, including qualified stand-alone dental plans (QDPs) offered through the Marketplace.[13] If not directly provided by CMS, a web-broker may obtain additional information on health plan products (QHPs and QDPs) that are displayed on its website directly from those health insurance

[13] As detailed in the Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule (77 Fed. Reg. 18310, 18315) (March 27, 2012), with some limited exceptions, SADPs are considered a type of QHP. CMS expects all web-brokers to follow the same requirements for SADPs as for QHPs, including display of all applicable SADPs offered through the Marketplace and all available information specific to each SADP on their websites, as well as including the Plan Detail Disclaimer to the extent that all required SADP comparative information is not displayed on their websites.

and QDP issuers with whom it has a contractual relationship. This standardized comparative information includes the following information, at a minimum:

a. Premium and cost-sharing information (total and net premium based on APTCs and CSRs);
b. Summary of benefits and coverage;
c. Identification of whether the QHP is a bronze, silver, gold, or platinum level plan, or a catastrophic plan;
d. Provider directory;
e. The results of an enrollee satisfaction survey;
f. Quality ratings;
g. Medical loss ratio information; and
h. Transparency of coverage measures reported to CMS during certification.

In accordance with 45 CFR §155.220(c)(3)(i), if a web-broker does not have access to the additional required comparative information for a QHP offered through the Marketplace, including premium and benefit information, it must prominently display the following mandatory standardized Plan Detail Disclaimer for the specific QHP:

> "[Name of Company] isn't able to display all required plan information about this Qualified Health Plan at this time. To get more information about this Qualified Health Plan, visit the Health Insurance Marketplace website at HealthCare.gov."

The mandatory standardized Plan Detail Disclaimer must:

- Be prominently displayed where plan information on the QHP would normally appear, so it is noticeable to the consumer;
- Be provided separately for each QHP where this information is missing;
- State that the comparative information for all QHPs offered through the Marketplaces is available on HealthCare.gov;
- Use the exact language provided by HHS; and
- Include an operational link to the Health Insurance Marketplace website (HealthCare.gov).

The Web-broker Enrollment Partner website:

1. Must, in accordance with 45 CFR §155.220(c)(3)(i), adhere to the website display standards specified in 45 CFR §155.205(c). CMS expects a web-broker to make available quality ratings information on each QHP offered through a Marketplace easily accessible to consumers, including consumers with disabilities and limited English proficiency.
2. Must, in accordance with 45 CFR §155.220(c)(3)(ii), provide consumers the ability to view all QHPs offered through the Marketplace. Web-brokers must display all QHPs available through a Marketplace, irrespective of compensation or appointment arrangements.

3. Must, in accordance with 45 CFR §155.220(c)(3)(iii) provide no financial incentives, such as rebates or giveaways.
4. Must, in accordance with 45 CFR §155.220(c)(3)(iv), disclose and display all QHP information provided by the Marketplace. Web-brokers must disclose and display all QHP information provided by the FFM or directly by QHP issuers with whom it has a contractual relationship. Similar to last year, CMS is providing a limited subset of 2015 QHP data for all individual market QHPs offered through the FFM (known as the2015 QHP Limited File). The 2015 QHP Limited File contains data for web-brokers to list all QHPs that are available to consumers on the FFM through HealthCare.gov, including QHPs offered in states performing plan management functions. This data will include:
   i. QHP issuer details: QHP issuer name, address, and contact information.
   ii. QHP details: QHP name, type of plan, level of coverage, and the state in which the QHP is offered.

   The 2015 QHP Limited File will NOT contain QHP rate, benefit, cost sharing, network, payment, uniform resource locator (URL), or service area information.
5. Must, in accordance with 45 CFR §155.220(c)(3)(vi), provide consumers with the ability to withdraw from the process and use the Marketplace website instead at any time.

Web-broker Enrollment Partner Websites must also prominently display the General non-FFM Disclaimer as in accordance with 45 CFR §155.220(c)(3)(vii). The disclaimer must read:[14]

> "Attention: This website is operated by [Name of Company] and is not the Health Insurance Marketplace website. In offering this website, [Name of Company] is required to comply with all applicable federal law, including the standards established under 45 CFR 155.220(c) and (d) and standards established under 45 CFR 155.260 to protect the privacy and security of personally identifiable information. This website may not display all data on Qualified Health Plans being offered in your state through the Health Insurance Marketplace website. To see all available data on Qualified Health Plan options in your state, go to the Health Insurance Marketplace website at HealthCare.gov.
>
> [Also, you should visit the Health Insurance Marketplace website at HealthCare.gov if:
>
> - You want to select a catastrophic health plan.
> - You want to enroll members of your household in separate Qualified Health Plans.

[14] Certain pieces of the disclaimer, indicated in brackets, are not required but CMS encourages a web-broker that does not offer these services to display the parts of the disclaimer corresponding to the certain products or services it does not offer.

- The plans offered here don't 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. Pediatric dental services are an essential health benefit.]"

The Web-broker Enrollment Partner must observe the following requirements for displaying the General non-FFM Disclaimer:

- The Disclaimer must be prominently displayed on both the initial consumer landing page and on the landing page displaying Qualified Health Plan options that appears before the applicant makes a decision to purchase coverage (QHP selection page).
- The Disclaimer must use the exact language provided by HHS.
- The Disclaimer must include a functioning web link to the Health Insurance Marketplace website (HealthCare.gov).

CMS requires all disclaimers, including the Web-broker General non-FFM and Plan Detail Disclaimers, to be "prominently displayed." CMS considers the disclaimers to be "prominently displayed," if they are:

- Viewable without requiring the user to select or "click on" an additional link;
- Written in a font size no smaller than the majority of the text on the webpage;
- Displayed in the same non-English language as any language(s) the web-broker maintains screens for on its website; and
- Noticeable in the context of the website (e.g., use a font color that contrasts with the background of the webpage).

Web-brokers may change the font color, size, or graphic context of the disclaimer to ensure that it is noticeable to the applicant in the context of the website. However, the exact language of the General non-FFM and Plan Detail Disclaimers must be used.

CMS expects that web-brokers participating in FFMs to prominently display language explaining to consumers that the web-broker has entered into an Agreement(s) with the FFM and has agreed to conform to the website display and security standards in 45 CFR §155.220(c)(3) and 45 CFR §155.260. In addition, CMS strongly suggests that web-brokers or other A/Bs not use "Marketplace" or "Exchange" in the name of their business or websites.

CMS expects web-brokers to display information for QHPs offered through the FFMs in a way that will not steer a consumer to a particular QHP based upon financial considerations alone. Web-brokers may offer additional tools or decision support that the consumer can use to navigate or refine the display of QHPs. CMS also expects that the web-broker will display language explaining to the consumer the specific source and nature of web-broker compensation and that compensation does not affect the display of QHP options or premiums charged. CMS expects that a web-broker will offer a QHP plan selection experience that is free from advertisements or information for other health insurance-related products and sponsored links advertising health insurance-related products (e.g., an advertisement for a QHP issuer). Once a consumer has completed the QHP plan selection and enrollment, the web-broker may offer the consumer the

ability to search for additional products or services if desired. CMS expects that such offers are made in a section of the web-broker's website that is separate from the QHP display and plan selection.

CMS generally expects that consumers are not charged a separate transaction or service fee for shopping or enrolling in a QHP through a web-broker's website. CMS recognizes that web-brokers may have invested significant resources to develop special software to assist consumers with selection and enrollment in QHPs offered through the FFM, and some independent A/Bs may leverage those websites to facilitate QHP selection and enrollment. CMS believes that in these limited circumstances, where there is a bona fide service of value that goes beyond the traditional assistance provided by an A/B registered with the FFM, it may be appropriate to allow for the collection of an additional fee. However, any practice of collecting such fees from consumers for providing assistance with QHP selection and enrollment through the FFM would be subject to applicable state law. If permitted under state law, A/Bs and web-brokers that elect to pass on these types of costs to consumers for selecting and submitting QHP applications offered through the FFM through a non-FFM website should provide a disclaimer to consumers that: 1) clearly discloses the amount and reason for the fee, and 2) informs the consumer that he/she can apply through the FFM website (HealthCare.gov) at no cost.

A web-broker can allow other A/Bs to use its website to enroll qualified individuals, employers, and employees in a QHP through the FFM by using a contract or other arrangement.[15] The agent or broker accessing the web-broker website pursuant to the arrangement should be listed as the agent of record on the enrollment. The web-broker must verify that any other agent or broker accessing its website is licensed by the applicable state(s), has completed applicable FFM training, has registered with the FFM, and has signed all required Agreements with the FFM.[16] The web-broker must display its name and identifier, such as the web-broker's NPN, on the website when it is made available to another agent or broker, even if the agent or broker is able to customize the appearance of the website.[17] The web-broker must terminate the other agent's or broker's access to its website if CMS determines that the agent or broker is in violation of applicable Marketplace requirements.[18] In addition, web-brokers must report to HHS and applicable state regulators any potential material breach of the A/B Marketplace requirements, including the privacy and security standards under 45 CFR §155.260(b) by the agent or broker accessing its website, should the web-broker become aware of any such potential breach.[19]

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[15] 45 CFR §155.220(c)(4).
[16] 45 CFR §155.220(c)(4)(i)(B).
[17] 45 CFR §155.220(c)(4)(i)(C).
[18] 45 CFR §155.220(c)(4)(i)(D).
[19] 45 CFR §155.220(c)(4)(i)(E).

4.5 MANDATORY ATTESTATIONS

QHP issuer Enrollment Partners using their websites to enroll individuals into QHPs in a manner considered to be through the FFMs will collect attestations for those households receiving APTCs as set forth in 45 CFR §156.1230(a)(1)(v). In the XML file that the FFMs send to QHP issuers related to eligibility, the FFMs, based on the information provided in the application, identify 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 FFMs.

5. SPECIAL ENROLLMENT PERIODS (APPLICABLE TO INDIVIDUAL MARKET FFMS, QHP/QDP)

Pursuant to 45 CFR §155.420, SEPs constitute periods outside the initial or OEP when a QI may enroll in a QHP/QDP or an enrollee may elect to change a current QHP/QDP selection.

5.1 AVAILABILITY AND LENGTH OF SEPS

The FFMs determine whether a QI or enrollee is eligible for an SEP based on the eligibility requirements described in 45 CFR §155.420(d).[20] Pursuant to 45 CFR §155.420(c), unless otherwise stated, SEPs in the FFMs generally last 60 days from the triggering event. The FFMs has the flexibility to define the length of the SEP as appropriate based on the circumstances for certain SEPs, including those for enrollment errors, exceptional circumstances, misrepresentation, and benefit display errors.[21]

A QI/enrollee may qualify for an SEP under §155.420(d) if the enrollee:

- Loses MEC
- Is enrolled in any non-calendar year group health plan or individual health insurance coverage
- Loses pregnancy-related coverage described under Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX))
- Loses medically needy coverage as described under Section 1902(a)(10)(C) of the Social Security Act only once per calendar year
- Gains a dependent or becomes a dependent through marriage, birth adoption, placement for adoption, placement in foster care, or a child support or other court order
- At the option of the Marketplace, loses a dependent or dependent status due to legal separation, divorce, or death
- Becomes a citizen or national, or gains lawfully present status

[20] In addition to the eligibility requirements established by 45 CFR §155.420(d), an Indian (as defined by Section 4 of the Indian Health Care Improvement Act) may enroll in a QHP or change from one QHP to another one time per month.

[21] A QI/enrollee described in 45 CFR §155.420(d)(1) and (d)(6)(iii) has 60 days before and after the triggering event to select a QHP. In the case of QIs/enrollees eligible for an SEP based on criteria in 45 CFR §155.420(d)(4), (d)(5), (d)(9), or (d)(10), the Marketplace may define the length of the SEP "as appropriate based on the circumstances of the SEP, but in no event shall the length of the SEP exceed 60 days."

- Is unintentionally, inadvertently, or erroneously enrolled or not enrolled in a QHP and it is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Marketplace or its instrumentalities, or a non-Marketplace entity
- Is enrolled in a QHP and becomes newly eligible/ineligible for APTCs, or changes in eligibility for CSRs
- Is enrolled in an eligible employer-sponsored plan and is determined newly eligible for APTCs, in part on a finding that such individual is ineligible for qualifying coverage in an eligible employer-sponsored plan in accordance with 26 CFR §1.36B-2(c)(3)
- Lives in a non-Medicaid expansion state, was formerly ineligible for APTCs solely due to household income below 100% FPL, is ineligible for Medicaid at the same time, and experiences a change in household income that makes the QI or enrollee newly eligible for APTCs
- Demonstrates to the Marketplaces that the QHP in which the enrollee or the enrollee's dependent is enrolled substantially violated a material provision of the contract in relation to that enrollee
- Gains access to a new QHP as a result of a permanent move, including release from incarceration
- Is an American Indian/Alaska Native, as defined by Section 4 of the Indian Health Care Improvement Act, which permits the enrollee to enroll in a QHP or change from one QHP to another one time per month
- Demonstrates to the Marketplaces that the enrollee or the enrollee's dependent meets exceptional circumstances, as defined by the FFMs

5.2 COVERAGE EFFECTIVE DATES

As described in 45 CFR §155.420(b)(1), the regular coverage effective date for a QHP selected by a QI/enrollee during an SEP is:

- The first day of the month following QHP selection if selection took place between the 1st and 15th day of any month; or
- The first day of the second month following QHP selection if selection took place between the 16th and the last day of any month.

However, if a QI/enrollee experiences a life event, such as marriage, birth, adoption, or placement in foster care, QI/enrollee qualifies for special coverage effective date**.** Exhibit 26 and Exhibit 27 summarize and provide examples of coverage effective dates for various SEPs within the FFMs.

Exhibit 26 – SEP Coverage Effective Dates Summary

SEP Event	FFMs Coverage Effective Date	Regulation
Loss of Coverage	**Plan selection before/on the day of loss of MEC:** First day of the month following loss of MEC **Plan selection after loss of MEC:** First day of the month following plan selection or regular coverage effective dates, at the option of the Marketplace	45 CFR §155.420(d)(1)
Permanent Move/ Incarceration	**Plan selection before/on the day of loss of MEC due to permanent move/incarceration:** First day of the month following loss of MEC **Plan selection after loss of MEC due to permanent move/incarceration:** First day of the month following plan selection or regular coverage effective dates, at the option of the Marketplace	45 CFR §155.420(d)(7)
Marriage	First day of the month following plan selection	45 CFR §155.420(d)(2)
Birth, Adoption, or Foster Care	Date of birth, adoption, placement for adoption, or placement in foster care; or, at the option of the Marketplace, the consumer may have the additional choice of the first day of the month following the life event or regular coverage effective date	45 CFR §155.420(d)(2)
Individuals Who Gain Dependent(s) Through a Child Support Order or Other Court Order	Effective date of the court order, or at the option of the Marketplace, consumers may have the additional choice of a regular effective date	45 CFR. §155.420(b)(2)(v),
Gaining Status as a Citizen, National, or Lawfully Present Individual	Regular coverage effective date	45 CFR §155.420(d)(3)
Newly Eligible or Ineligible for APTCs or Change in CSRs	Regular coverage effective date	45 CFR §155.420(d)(6)

SEP Event	FFMs Coverage Effective Date	Regulation
Native American Status	Regular coverage effective date	45 CFR §155.420(d)(8)

Exhibit 27 – SEP Effective Date Examples

Trigger Event	Trigger Event Date	SEP Start Date	SEP End Date (FFMs-60 days)	Plan Selection Date Examples	Enrollment Effective Dates
*Permanent Move^*	4/1	4/1	5/31	4/15	5/1
Permanent Move	4/10	4/10	6/8	4/25	5/1 or 6/1
*Birth**	6/1	6/1	7/31	6/29	6/1, 7/1 or 8/1††
*Birth**	8/25	8/25	10/23	9/15	8/25, 9/1 or 10/1††
*Birth**	12/26	12/26	2/24	1/13	12/26, 1/1 or 2/1††
Loss of Coverage†	4/28	4/28†	6/27	3/10	5/1
Loss of Coverage†	4/15	4/15†	6/14	5/20	6/1 or 7/1††
Loss of Coverage†	5/12	5/12†	7/11	6/7	7/1
*Loss of Medicaid***	4/28	4/28	6/27*	5/20	6/1 or 7/1††
Loss of CHIP	5/12	5/12	7/10*	7/10	8/1
Marriage	4/12	4/12	6/11	4/29	5/1
Marriage	7/1	7/1	8/30	7/20	8/1

*Per 45 CFR §155.420 (b)(2)(i), Marketplaces may provide flexibility for coverage effective dates in the case of birth, adoption, placement for adoption, or placement in foster care. The Marketplaces are required to ensure that coverage is effective for a QI or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care, unless the Marketplaces permit the QI or enrollee to elect a later coverage effective date for the first of the month following the date of the event or following regular coverage effective rules.
†Per 45 CFR §155.420(c)(2)(i), QIs eligible for loss of coverage SEPs have 60 days before and after the triggering event to select a QHP.
**Loss of Medicaid/CHIP qualifies a QI/enrollee for a 60 day SEP. Note: Consumers who apply during the OEP or due to a qualifying LC and are assessed Medicaid/CHIP eligible by the FFMs, but later determined ineligible for Medicaid/CHIP by the state, and are then determined eligible for QHP coverage can request a retroactive coverage effective date back to the coverage effective date they would have received if they were originally determined eligible for QHP coverage.

††It is at the option of the Marketplaces to provide consumers the additional options of accelerated or regular coverage effective dates. FFMs only provide coverage back to date of the event at this time.
^Effective April 28, 2015, it is at the option of the Marketplaces to allow advance reporting of up to 60 days prior to a permanent move, including release from incarceration.

5.3 LOSS OF COVERAGE

In addition to the loss of MEC, as described in 45 CFR §155.420(d)(1), loss of coverage also includes the following events:

- **Non-calendar Year Individual Health Policy Renewal**: Pursuant to 45 CFR §155.420(d)(1)(ii), the FFMs permit QIs and their dependents to enroll in or change from one QHP to another if they are enrolled in a non-calendar year group health plan or individual health insurance coverage even if issuers of such non-calendar year policies offer to renew the policy. This provides consumers who renew coverage outside the OEP with an opportunity to enroll in the FFMs.
- **Loss of Pregnancy-related Services**: Pursuant to 45 CFR §155.420(d)(1)(iii), the FFMs permit QIs and their dependents to enroll in a new QHP if they lose eligibility for pregnancy-related services. This provision is to ensure that women losing eligibility for coverage of pregnancy-related services, as described in Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)), are not left without an option to enroll in a QHP after the conclusion of Medicaid eligibility.
- **Loss of Medically Needy Coverage**: Pursuant to 45 CFR §155.420(d)(1)(iv), the FFMs permit QIs and their dependents to enroll in a new QHP if they lose eligibility for medically needy coverage as under Medicaid is described in Section 1902(a)(10)(C) of the Social Security Act. This SEP enables individuals with only medically needy Medicaid coverage to enroll in a QHP outside of the OEP when the individual reaches the end of his or her medically needy budget period within the same calendar year. The individual qualifies for one SEP for loss of medically needy coverage per calendar year.

5.3.1 Complex Case SEPs

The SEPs listed below reflect the guidance published by CMS on May 26, 2014, "Guidance for Issuers on Special Enrollment Periods for Complex Cases in the FFM after the Initial OEP," available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/complex-cases-SEP-3-26-2014.pdf. Pursuant to the SEP categories in 45 CFR §155.420(d)(4) and 45 CFR §155.420(d)(9), individuals may be determined eligible for an SEP. CMS has determined that these SEPs will result in prospective coverage effective dates unless stated otherwise. Complex cases that may qualify a QI or enrollee for an SEP include:

- Being assessed eligible for Medicaid/CHIP by the Marketplace, but then determined ineligible for Medicaid/CHIP by the state Medicaid/CHIP agency

- Being a victim of domestic abuse or spousal abandonment
- Other situations determined appropriate by CMS

5.4 HHS-GRANTED SEPS

Several categories of SEPs exist that allow QIs to enroll in QHPs with modified effective dates, in addition to changing their QHP selection. These SEP types are called HHS-granted SEPs. Some of the most common circumstances under which CMS is providing HHS-granted SEPs include:

- **Enrollment error SEPs** (granted under 45 CFR §155.420(d)(4)): when QIs chose a plan by the appropriate deadline but, due to a technical error, the enrollment either was not processed correctly or the issuer does not have the enrollment.
- **Exceptional circumstance SEPs** (granted under 45 CFR §155.420(d)(9)): when QIs experience a situation that the Marketplace determines has prevented enrollment in a QHP by the applicable deadline, such as a natural disaster or a medical emergency. Note that exceptional circumstance SEPs may be granted for additional situations in accordance with guidelines issued by HHS.
- **Misrepresentation SEPs** (granted under 45 CFR §155.420(d)(4)): when misconduct by individuals or entities providing formal enrollment assistance (like an insurance company, Navigator, certified application counselor, Marketplace Call Center representative, or FFM-registered A/B) results in QIs' unintentional, inadvertent, or erroneous enrollment or non-enrollment in a QHP.
- **Plan display error SEPs** (granted under 45 CFR §155.420(d)(4))**:** when incorrect plan data, such as plan benefit and cost-sharing information, was displayed on Plan Compare at the time the QI selected the QHP.

Some of these SEPs, such as the enrollment error and exceptional circumstance SEPs, can be granted when QIs have not yet enrolled in a QHP, while others, such as plan display errors or some misrepresentation SEPs, may be granted after an enrollment has been effectuated.

5.4.1 Process for Obtaining an HHS-granted SEP

QIs seeking an HHS-granted SEP will need to call the Marketplace Call Center. Call center representatives will forward cases to CMS caseworkers to determine their eligibility for an SEP, if needed. If QIs have already been determined eligible for an SEP, call center representatives will help the QI complete the plan selection process. If the SEP is granted and a new enrollment is processed, a record will be assigned to the issuer through HICS directing the issuer to change the coverage effective date, if applicable.

To terminate prior coverage on a date that will align with the new coverage effective date, the issuer will need to honor an enrollees' requests to terminate their prior coverage the day before the new QHP's coverage effective date, pursuant to 45 CFR §155.430(d)(6).

5.4.2 Coverage Effective Dates for HHS-granted SEPs Other Than Plan Display Errors

For HHS-granted SEPs other than plan display errors, the date that the enrollment error, exceptional circumstance, or misrepresentation occurred is the event that triggers the SEP. Pursuant to 45 CFR §155.420(b)(2)(iii), a Marketplace may provide for a coverage effective date that is either: (1) based on the date of the SEP-triggering event, which provides QIs with their initially intended coverage effective date; or (2) based on the date of the plan selection during the SEP window, which provides QIs their regular effective dates.

In the FFMs, QIs will be eligible to receive their intended coverage effective date if they take timely action to contact the Marketplace Call Center to request an SEP before the initially intended coverage effective date passes. Taking action before the coverage effective date passes indicates to CMS that the QI had intended to enroll in coverage by the initially intended coverage effective date and would have had their coverage effectuated had the event that triggered the SEP not occurred.

5.4.3 Plan Display Errors

Plan display errors occur when an issuer or Marketplace error results in incorrect plan data being displayed to QIs on HealthCare.gov's Plan Compare. This can include, but is not limited to, errors in premium, benefits, and cost sharing. QIs affected by plan display errors may be eligible for an SEP to return to the Marketplace and select another QHP.

Unlike the other HHS-granted SEPs, QIs eligible for a plan display SEP are typically already enrolled in a QHP, which requires the SEP process to accommodate the additional complexity of terminating enrollment in the original QHP if the QIs enrolls in a different QHP during the SEP period. Additionally, QIs generally need to be notified of their eligibility for this SEP.

5.4.3.1 Identifying and Resolving Plan Errors

Plan display errors are identified after CMS investigates potential display discrepancies raised by issuers or QIs or noticed by CMS. Marketplace plan display errors include situations where coding on HealthCare.gov causes benefits to display incorrectly, or where CMS identifies an incorrect QHP data submission or a discrepancy between an issuer's QHP data and its state-approved form filings. If a coding error is identified, CMS will determine whether other QHPs are affected by the same error and will reach out to other affected issuers. When a plan display error is identified, CMS will work with the issuer to ensure that the error is corrected as quickly as possible to ensure that enrollments moving forward are based on accurate plan data.

In some cases, the corrected plan data either reduces a benefit or increases costs to QIs. CMS will work with the issuer and a state's Department of Insurance to arrive at a solution that has a minimal impact on impacted QIs and affirms, to the extent possible, that they are not negatively affected by this Marketplace or issuer error.

Generally, the most straightforward and consumer-friendly resolution is for issuers to honor the benefit as it was displayed incorrectly for affected enrollees. If the issuer honors the benefit and administers the plan as it was incorrectly displayed for the affected enrollees, no further action is needed.

Issuers That Do not Honor the Plan Information That Displayed Incorrectly

CMS is committed to making sure, to the extent possible, that QIs are not negatively affected by Marketplace or issuer plan display errors. Depending on the significance of the plan display error, there are several options to mitigate the impact on the QI.

If the plan display error is significant and it is reasonable to expect that it may have affected a QI's purchasing decision, then QIs will be notified of the error and provided a plan display error SEP. The SEP will provide QIs with the option to select another plan—either from the same issuer or another issuer available to the QI—but it does not generally require QIs to do so if QIs wish to stay enrolled in their existing plan with the correct benefits.

If a plan display error is minor and likely has little impact on QIs, QIs may still be eligible for an SEP at their request.

5.4.3.2 Processing Plan Display Error SEPs

CMS allows an SEP-qualified individual already enrolled in a QHP to select a new QHP by calling the Marketplace Call Center. The Call Center will help the QI update the individual's information as needed and complete the process of selecting a QHP. QIs generally have 60 days from the notification of the plan display error to select a new plan.

Under 45 CFR §155.420(b)(2)(iii), a Marketplace may provide for a coverage effective date that is either: (1) based on date of the SEP-triggering event, which provides the enrollee his or her initially intended coverage effective date; or (2) based on the date of the plan selection during the SEP window, which provides the enrollee regular effective dates. Accordingly, the new coverage generally will be effective based on the date the new plan was selected. In some cases, QIs can elect retroactive coverage to the initially intended coverage effective date; however, the use of retroactive coverage dates will be limited to those circumstances where it is necessary to avoid significant economic harm to QIs.

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

The coverage effective date for the new QHP will be communicated to the new issuer through HICS if it is different from what the system automatically assigns. The issuer will need to terminate the coverage when the QI has selected another QHP during an SEP.

6. PREMIUMS (APPLICABLE TO INDIVIDUAL MARKET FFMS, QHP/QDP)

6.1 PREMIUM PAYMENT THRESHOLD

QHP and QDP issuers may implement a premium payment threshold policy for their plans offered through an FFM. QHP and QDP issuers that elect to establish such a policy generally may consider a payment to have been made in full once the enrollee pays an amount equal to or greater than the threshold amount established by the issuer, even if this is less than the total amount owed by the enrollee. CMS recommends that issuers who choose to implement such a policy base the payment threshold on a percentage of the enrollee-responsible portion of the overall premium.[22] CMS strongly recommends a percentage equal to or greater than 95%.

In accordance with rules that rates must be standard and consistent in the Marketplaces, QHP and QDP issuers that choose to apply a payment threshold policy should apply the policy equally across all enrollees. Additionally, if the issuer adopts such a policy, it should be applied to the initial premium payment and/or any subsequent premium payments.

Under this type of policy, 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 or QDP 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 or QDP 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 <u>all</u> past due premium amounts before the end of the applicable grace period to avoid termination for non-payment of premium. Exhibit 28 illustrates an example of the premium payment threshold policy in action.

[22] The enrollee-responsible portion is equal to the total premium minus APTCs.

Exhibit 28 – Premium Payment Threshold Lifecycle

Date	Action	Comments
December 10	QI selects QHP ($100 enrollee-responsible portion after APTCs)	QHP issuer has a premium payment threshold of 95%.
December 16	Enrollee billed $100 for first month's premium	Enrollee's first month of coverage is January.
December 28	Enrollee pays $97 for January coverage	The payment is within the threshold tolerance, so coverage is effectuated on January 1.
January 16	Enrollee billed $100 for February coverage, and $3 past-due from January	The total amount billed is $103.
February 1	Enrollee pays $97	$3 is applied to January coverage and $94 is applied to February coverage. $94 is not within the threshold tolerance, so the issuer places the enrollee into a grace period due to the enrollee's delinquency status as of February 1. January is paid in full. February is $6 past due.
February 16	Enrollee billed $100 for March coverage, and $6 past-due from February	The total amount billed is $106. No payment is received from the enrollee.
March 16	Enrollee billed $100 for April coverage, $100 from March, and $6 past-due from February	The total amount billed is $206. No payment is received from the enrollee.
April 16	Enrollee billed $100 for May coverage, $100 from April, $100 from March, and $6 past due from February	The total amount billed is $306. No payment is received from the enrollee.
April 25	Enrollee pays $202	$6 is applied to February (paid in full); $100 is applied to March (paid in full); and $96 is applied to April (the enrollee is still in the grace period).
April 30	Enrollee makes no payment	No payment is received by April 30. If the enrollee does not pay $4 by April 30, then the enrollee's coverage will be terminated effective February 28.

Date	Action	Comments
May 1	Coverage terminated for failure to pay premiums effective February 28; issuer refunds $196 to enrollee	If the enrollee had paid the $4 balance on April 30, the enrollee would have satisfied premium payments to end the grace period; however, the enrollee would still owe $100 for May. If the enrollee then failed to pay the May premium (within the threshold) by the due date, the grace period would start again.

6.2 PRORATION OF PREMIUMS AND APTCS

Policy is pending.

6.3 TERMINATIONS FOR NON-PAYMENT OF PREMIUMS

In accordance with 45 CFR §155.430(b)(2)(ii) and 45 CFR §156.270, a QHP/QDP may terminate an enrollee's coverage for non-payment of premiums. Additionally, 45 CFR §156.270 requires issuers to 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 a threshold) of their portion of the monthly premium. However, an issuer's standard policy must follow certain requirements. 45 CFR §156.270(d) requires issuers to observe a three consecutive month grace period before terminating coverage for those enrollees who are eligible for and have elected to receive APTCs and who have paid at least one month of premium in full (or paid within the premium payment threshold if the issuer utilizes such a threshold). An enrollee who is eligible for APTCs, but elects not to receive any APTCs, is not eligible for the three consecutive month grace period, but is eligible for the grace period the issuer normally provides to individuals who become delinquent in paying their premiums, in accordance with state law.

In the case where an enrollee receiving APTCs is enrolled in both a QHP and a QDP, if the APTCs are applied and paid for both a QHP and QDP, the enrollee is eligible for the three consecutive month grace period for both the QHP and QDP. The enrollee is not eligible for the three consecutive month grace period for the QDP if the enrollee's APTCs are applied and paid only for the QHP.

To avoid termination, an enrollee must pay all outstanding premiums in full prior to the end of the applicable grace period. A grace period does not "reset" when a partial payment is made. If a QHP or QDP issuer makes use of a premium payment threshold, and an enrollee fails to make payment within the threshold tolerance, triggering the applicable grace period, the payment threshold no longer applies. The enrollee must pay <u>all</u> past due premium amounts before the end of the applicable grace period to avoid termination for non-payment of premiums.

When an enrollee's coverage is terminated for non-payment of premiums, per 45 CFR §155.420(e), the individual does not qualify for an SEP for the resulting loss of coverage. However, if the individual becomes eligible for an SEP based on other circumstances, the individual may enroll in a QHP or QDP, including the QHP or QDP from which they were terminated for non-payment. Additionally, during the annual OEP, consumers whose coverage was terminated for non-payment of premiums before the end of the plan year will be able to apply for an eligibility determination, and, if determined eligible, will be permitted to select a QHP for coverage for the upcoming plan year.

If, during an SEP or the annual OEP that occurs after termination for non-payment of premiums, a QI selects a plan offered by the same issuer that terminated their previous enrollment, the enrollment under the SEP or annual OEP would be considered a new enrollment. Accordingly, under the guaranteed availability requirements, the issuer would not be able to attribute any payment from the QI toward the outstanding debt from the prior, terminated enrollment and then refuse to enroll the applicant based on failure to pay premiums. The QI will be required to pay the first month's premium in accordance with 155.400(e) to have coverage effectuated, and the QHP or QDP must return either an 834 confirmation/effectuation or a cancellation transaction to the Marketplaces, as applicable.

Appendix B includes an example of the content an issuer might consider in a letter providing notice of non-payment of premiums. The specific wording and messages included in Appendix B are not required, but are offered as recommendations for elements in the plan's notice of non-payment when an enrollee receives APTCs.

Examples

Example 6A: An enrollee is eligible for, but has elected not to receive, APTCs. The enrollee's monthly premium is $200 and the issuer does not make use of a premium payment threshold. The enrollee, whose coverage was effectuated for May 2015, has not paid the June 2015 premium, which was due on June 1, 2015. The QHP issuer's standard policy, in accordance with state law, is to allow a one-month grace period for enrollees not receiving APTCs. On June 10, 2015, 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 30, 2015. The QHP issuer can apply the $50 payment toward the premium owed for June, if permitted by applicable state law.

Example 6B: An enrollee receiving APTCs is responsible for a $150 monthly premium payment and the issuer does not make use of a premium payment threshold. The enrollee's coverage is effectuated and the enrollee pays the premiums through May, but fails to make payment for the June premium, therefore entering the three consecutive month grace period that will run through August 31, 2015. The enrollee fails to make any payment for the July 2015 premium, and now owes the QHP issuer $300. On July 10, 2014, the enrollee pays $200. Since the enrollee has not paid the entire outstanding premium for which he or she is responsible, the enrollee remains in the three consecutive month grace period that started June 1, 2015. The enrollee fails to make

any further payments, and on August 31, 2015, the QHP issuer sends an 834 termination transaction to the FFM containing a termination effective date of June 30, 2015. The QHP issuer can keep $150 of the $200 payment to cover June premium, but has to refund the remaining $50 in accordance with state law.

Example 6C: Circumstances are the same as Example 6B except that on July 11, 2015, the enrollee pays $300. Since the enrollee has paid the entire outstanding premium balance for which the he or she is responsible, the enrollee is no longer in the grace period. However, if the enrollee fails to make full payment for August 2015 by the payment due date, the enrollee will enter into a new three consecutive month grace period beginning August 1, 2015.

Example 6D: An enrollee who is not receiving APTCs is enrolled in QHP A and fails to pay the July 2015 premium, due July 1, 2015. Because the enrollee is not receiving APTCs, the issuer may terminate the enrollee's coverage, subject to applicable state grace period requirements, which are assumed for this example to be a grace period expiring after one month. The enrollee enters into the grace period on July 1, 2015, and the grace period expires July 31, 2015. The enrollee makes no further premium payment, and the enrollee's coverage is terminated by the QHP with an effective date of July 31, 2015, which complies with applicable state law. The former enrollee subsequently qualifies for an SEP and is determined to be eligible for coverage. On August 13, 2015, the QI again selects QHP A and is provided an effective date of September 1, 2015. The QI makes the September premium payment in accordance with 155.400(e). The QHP issuer is not permitted to apply the September premium payment to the unpaid premium that led to the July termination and then refuse to effectuate the new enrollment. The QHP issuer must accept the enrollment and send the Marketplace an 834 effectuation transaction.

Example 6E: An enrollee who is receiving APTCs is enrolled in QHP B, has been paying premiums in full since January 1, 2015, and fails to pay the August 2015 premium, due August 1, 2015. The enrollee enters the three consecutive month grace period on August 1, 2015, which would expire October 31, 2015. The enrollee makes no further premium payment, and the enrollee's coverage is terminated by the QHP issuer, effective August 31, 2015. Since CMS begins auto-reenrollment in mid-October, before the termination transaction was processed, CMS may initially send a 2016 passive reenrollment for this enrollment because it was in good standing at the time of auto-reenrollment. However, CMS will send a cancellation transaction for the passive reenrollment in the 2016 policy after the 2015 termination is processed because the individual is no longer eligible for auto-reenrollment. However, during the annual OEP, the individual logs into HealthCare.gov and updates his or her application for the upcoming plan year and is determined eligible for coverage and for APTCs. The QI again selects QHP B for coverage starting January 1, 2016, and pays the first month's premium in accordance with 155.400(e). The QHP issuer is not permitted to apply the January 2016 premium payment to the unpaid premium from the enrollment terminated in August 2015. The QHP issuer must accept the new enrollment and send the Marketplace an 834 confirmation/effectuation transaction.

Example 6F: On January 5, 2015**,** an enrollee completes an application for enrollment through an FFM, makes a plan selection, and enrolls in QHP A with an effective date of February 1,

2015. The enrollee is eligible for, and elects to receive, APTCs and the portion of the monthly premium for which he or she is responsible is $100. The QI pays the first month's premium and his or her coverage is effectuated for February 1, 2015. After receiving the bill for the March premium, the enrollee pays $50 and makes no further payments for March 2015. On March 1, 2015, the enrollee enters into a three consecutive month grace period. On March 5, 2015, the QHP A issuer bills the enrollee $100 for April 2015, making the total outstanding premium $150. On March 20, 2015, the enrollee sends the issuer $40. The QHP A issuer may apply the enrollee's $40 payment to his March 2015 premium. Consequently, the enrollee owes $10 for March 2015 and $100 for April 2015. On April 5, 2015, the issuer bills the enrollee $100 for May premium, increasing his or her total outstanding premium to $210. On April 20, the enrollee sends the issuer $120. The issuer may apply $10 to the enrollee's outstanding March 2015 premium, $100 to his or her outstanding April 2015 premium, and $10 to his or her May 2015 premium. The enrollee makes no further payments before May 31, 2015, the final day of the three consecutive month grace period. The issuer terminates the enrollee's coverage, effective March 31, 2015, for non-payment of premium and must refund the enrollee $110 in premium paid for April and May 2015.

6.4 PAYMENT FOR REDETERMINATIONS OR RENEWALS

For renewals (generally, reenrollment into a plan under the same product offered by the same issuer of the QI's previous plan), issuers may continue to bill the enrollee via their existing billing cycle and a binder payment of the first month's premium is not required by the FFM. Non-payment of the January premium by the due date set by the issuer will trigger the applicable grace period. If a consumer is not on the enrollee switched list, and the issuer has not received an active reenrollment by December 15 (unless active reenrollments are prevented by state law), the issuer is encouraged to delay auto-draft payments for renewals into January coverage until the FFMs have acknowledged sending all passive reenrollments to that issuer. Payments drawn by the issuer or mistakenly provided by the enrollee for January coverage for enrollees who have selected a different issuer for coverage for the upcoming plan year must be promptly refunded.

6.5 PENDING CLAIMS

For enrollees receiving APTCs, who are within the second or third months of the three consecutive month grace period, issuers may pend claims for services rendered, if permitted by state law. If the enrollee is enrolled in both a QHP and a QDP, is receiving APTCs for both plans, and is in the second or third months of the three consecutive month grace period for both forms of coverage, both the QHP and QDP issuers may pend claims, if permitted by state law. If the issuer terminates the enrollee's coverage for non-payment of premiums, the issuer may deny any claims that were pended during the second and third months of the three consecutive month grace period. However, the issuer cannot retroactively deny claims from the first month of the three consecutive month grace period. Any premium collected by the issuer for coverage beyond the designated retroactive termination date should be refunded to the enrollee whose coverage was terminated.

6.5.1 Notification to Providers of Pended Claims

In accordance with 45 CFR §156.270(d)(3), QHP and QDP issuers must notify providers of the possibility of denied claims for services incurred during months two and three of the three consecutive month grace period for enrollees receiving APTCs. CMS expects 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.

6.5.2 Grace Period Spanning Two Plan Years

The grace period for non-payment of premiums could span two plan years if enrollees are receiving APTCs, have paid at least one full month's premium during the plan year, and fail to pay their premium in full or in an amount necessary to satisfy a payment threshold, if applicable, for November or December coverage. If the enrollees are still covered in December, and have not taken action actively to select a QHP for enrollment for the upcoming plan year, the Marketplaces will automatically send the 834 renewal transaction to the QHP. If the issuer sends an auto-renewal transaction, or if enrollees actively complete a plan selection to renew in a plan offered under the same product with the same issuer they have for their current coverage (or, where the product under which the QHP in which he or she is enrolled is not available through the individual market Marketplace for renewal in a plan under a different product offered by the same QHP issuer, to the extent permitted by applicable state law)[23], the QHP issuer must accept the enrollment, because enrollees are still in a grace period, meaning that the issuer may not discontinue enrollees' coverage based on failure to pay their premiums. For both auto-renewals and active selection renewals, the issuer may attribute enrollee payments to the oldest outstanding debt in the existing grace period for enrollees receiving APTCs.

[23] Pursuant to the Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges, 79 FR 52994 (September 5, 2014), when a product that included QHPs no longer offers QHPs through a Marketplace (for example, if the issuer does not apply for recertification of any plans within the product, but continues to offer the product in the market), and enrollees in that product are reenrolled in a QHP under a different product pursuant to 45 CFR §155.335(j)(2), that reenrollment would be considered a renewal, consistent with 45 CFR §147.106, and would be considered a renewal for purposes of determining whether the issuer could attribute any payment from the individual toward any outstanding debt that may exist between the individual and that issuer and then refuse to enroll the applicant or terminate the applicant's enrollment based on failure to pay premiums.

However, consistent with 45 CFR §156.270 and §155.430, if the enrollee does not pay all outstanding premiums by the end of the three consecutive month grace period, the issuer must terminate the enrollee's coverage retroactively to the last day of the first month of the grace period. Since the coverage in the new plan year resulted from a renewal of the terminated coverage, the coverage that was renewed for the subsequent plan year also will be terminated.

If the OEP extends long enough into the plan year, the enrollee may still have time left in the OEP to select a QHP for the remainder of year. In such cases, if the QI is eligible for coverage through the Marketplace, and the QHP issuer from which the QI was terminated for non-payment of premiums still offers QHPs through that Marketplace, the QI can select a QHP from that issuer. In these situations, the issuer may not apply any premium payment made for the new coverage to any outstanding debt from any previous coverage, and must accept the enrollment under the guaranteed availability requirements in 45 CFR §147.104. Like other enrollees, the QI will be required to pay the first month's premium to have coverage effectuated, and the QHP issuer must return either an 834 confirmation/effectuation or a cancellation transaction to the Marketplace, as applicable.

In other cases, an enrollee's three consecutive month grace period that started during the enrollee's current coverage year might expire after the close of annual OEP for 2016. In these situations, per 45 CFR §156.270 and §155.430, if the enrollee has not paid all outstanding premiums by the end of the grace period, the QHP must terminate the enrollee's coverage retroactively to the last day of the first month of the grace period, and the individual will not be able to enroll in the Marketplace until the next annual OEP, unless he or she qualifies for an SEP.

During the OEP, enrollees may decide not to renew their coverage and instead may make an active plan selection to enroll in a different product and/or with a different issuer for coverage for the upcoming plan year. In these cases, the QHP issuer must accept the enrollment under guaranteed availability rules. The enrollees will be required to pay the first month's premium in accordance with 155.400(e) to have the new coverage effectuated, and the QHP issuer must return either an 834 confirmation/effectuation or a cancellation transaction to the Marketplaces, as applicable. If enrollees choose a different product from the same issuer when the current product remains available, the issuer would not be able to attribute any payment from the enrollees toward any outstanding debt that may exist between the enrollees and that issuer and then refuse the enrollment.

Examples

Example 6G: An enrollee, who is receiving APTCs, is enrolled in QHP C. The enrollee has paid premiums in full throughout 2015, but fails to pay the December 2015 premium by the December 1, 2015 due date, and enters a three consecutive month grace period that would end on the last day of February 2016. The enrollee does not actively select a plan for the 2016 Plan Year, and the FFM sends an auto-renewal transaction. The QHP issuer must accept the enrollment. The renewed coverage continues into 2016, subject to the existing grace period. The enrollee does not pay all outstanding premiums by February 29, 2016, and the QHP retroactively terminates the enrollee's

coverage, effective December 31, 2015. The individual is no longer covered for the 2016 Plan Year. Since the annual OEP has ended, the individual cannot enroll in the Marketplace until the next annual OEP, unless the individual qualifies for an SEP.

Example 6H: Same facts contained in Example 6G, except the enrollee fails to pay the November premium by the November 1, 2015, due date, and enters a three consecutive month grace period that would end on the last day of January 2016. During the OEP, on December 4, 2015, the enrollee logs into HealthCare.gov, updates his or her application for the upcoming plan year, and is determined eligible for coverage. The enrollee actively renews coverage in QHP C for January 1, 2016, and pays the first month's premium by the due date. Because the enrollee decided to renew his or her coverage in the same product, the QHP may apply the January premium payment to the November non-payment. Because the enrollee is still within the three consecutive month grace period, the issuer may not refuse to effectuate the renewal enrollment. However, if the enrollee does not pay all outstanding premiums by January 31, 2016, the QHP must retroactively terminate the enrollee's coverage, effective November 30, 2015. The enrollee is no longer covered for the 2016 Plan Year and the QHP issuer must send the FFM a termination transaction for the 2015 plan, effective November 30, 2015, and a cancellation transaction for the 2016 plan, effective January 1, 2016.

6.5.3 Grace Periods Ending December 31

In some cases, an enrollee's grace period may be due to expire on December 31. Because the enrollee will still be covered in December, the enrollee may enroll in a different product, or may renew coverage, either through an active plan selection or through the FFMs' auto-renewal process described above.

If an 834 transaction is sent to renew enrollment in a plan under the same product under which the enrollee is currently covered,[24] and the enrollee has not paid all outstanding premium amounts due in accordance with the applicable grace period requirements, the QHP or QDP has the option to accept or reject the renewal. With regard to accepting renewals, the QHP or QDP issuer may not discriminate based on health status or other prohibited bases, and should apply the same policy consistently for all individuals in the same circumstances.

If the enrollee has decided not to renew coverage and, instead, makes an active plan selection to enroll in a different product and/or with a different issuer for 2015 coverage, the QHP or QDP issuer must accept the enrollment under guaranteed availability rules. The QI will be required to pay the first month's premium in accordance with 155.400(e) to have coverage effectuated, and

[24] See Footnote 15.

the issuer must return either an 834 confirmation/effectuation or a cancellation transaction to the Marketplace, as applicable. The issuer would not be able to attribute any payment related to the new enrollment toward any outstanding debt that may exist between the QI and that issuer and then refuse to enroll the QI or terminate the QI's enrollment based on failure to pay premiums.

Examples

Example 6I: An enrollee who is not receiving APTCs is enrolled in QHP D and fails to pay the December premium, due December 1, 2015. Because the enrollee is not receiving APTCs, the issuer would be able to terminate the enrollee's coverage, subject to state grace period requirements, assumed for this example to be one month. Therefore, the enrollee enters into the grace period on December 1, 2015, and the grace period expires December 31, 2015. The individual does not actively select a plan for 2016 coverage by the deadline for January 1, 2016 coverage. Because the enrollee remains enrolled through December 31, 2015, and has not taken action to update his or her enrollment, and because QHP D will continue to be offered in the upcoming year, the Marketplace sends an auto-renewal transaction to the QHP issuer before December 31, 2015.

The enrollee does not pay all outstanding premiums by December 31, 2015, so QHP issuer terminates the enrollee's coverage for non-payment and rejects the renewal, returning an 834 cancellation transaction to the Marketplace. Subsequently, the former enrollee logs into HealthCare.gov during the OEP on January 5, 2016, updates his or her eligibility information, and is determined eligible for coverage. The QI selects QHP D again for coverage starting February 1, 2016 and pays the first month's premium by the due date. The QHP issuer is not permitted to apply the new enrollment binder payment to the unpaid premium that led to the December termination. The QHP issuer must accept the enrollment. The QHP issuer sends the Marketplace an 834 confirmation/effectuation transaction.

Example 6J: An enrollee who is receiving APTCs is enrolled in QHP E and has been paying premiums in full since January, but fails to pay the October premium, due October 1, 2015. The enrollee therefore enters the three consecutive month grace period on October 1, 2015, which would expire December 31, 2015. During the OEP, on December 10, 2015, the enrollee logs into HealthCare.gov, updates his or her application for the upcoming plan year, and is determined eligible for coverage. The enrollee actively selects to renew coverage in QHP E starting January 1, 2016, and pays the first month's premium by the due date.

Since the enrollee actively selected to renew 2016 coverage into the same product, the QHP issuer may apply the January premium payment to the unpaid October premium. If the enrollee does not pay all outstanding premiums due for the grace period ending December 31, 2015, the enrollee's coverage during the 2015 plan year will be terminated with a retroactive effective date of October 31, 2015, and his or her 2015 coverage will be cancelled, effective January 1, 2016, leaving the enrollee with a gap in coverage for November and December. Subsequently, the QI whose coverage was terminated logs into HealthCare.gov during the OEP on January 10, 2016,

and selects QHP E again for coverage starting February 1, 2016, and pays the first month's premium by the due date. The QHP issuer is not permitted to apply the binder payment for new coverage effective February 1, 2016, to the unpaid premium that led to the October termination. The QHP issuer must accept the enrollment and send the Marketplace an 834 confirmation/effectuation transaction.

6.6 OVER-BILLIED PREMIUMS

QHP and QDP issuers may correct any over-billed premium amount, which is when an issuer for an erroneously high premium amount, according to their own policies and consistent with applicable state law. Issuers must, within a reasonable time of the discovery of the over-billing, credit the over-billed premium to the enrollees' accounts, refund the over-billed amount to the enrollees, or use a combination of both solutions.

QHP and QDP issuers must reduce the APTC amount in their systems if the total amount of APTCs applied to an enrollee's account exceeds total plan premium. Any resulting APTC discrepancies would be addressed during enrollment reconciliation**.**

6.7 UNDER-BILLED PREMIUMS

The term "under-billed premium" refers to a circumstance where an issuer bills an enrollee an erroneously low premium amount (or does not bill the enrollee at all). In a state where CMS directly enforces the Marketplace rules, CMS will consider exercising enforcement discretion to allow issuers to forego collection of under-billed premium on a case-by-case basis. In a state that has retained primary enforcement authority of the Marketplace rules, CMS generally defers to the relevant state authority. Therefore, the relevant state authority may direct or permit an issuer to forego the collection of any under-billed portions of premiums. Such action alone will not constitute a failure to substantially enforce premium-related requirements, as long as state policies are applied consistently and in a non-discriminatory fashion. Should any issuer forego collection of any under-billed premium, either under an exercise of CMS enforcement discretion or at the direction of the applicable state authority, the issuer must characterize the uncollected premiums as realized/earned premium for purposes of medical loss ratio (MLR), risk adjustment (RA) data submission, and risk corridors (RC) reporting.

Examples

Example 6K: On January 5, 2015**,** Enrollee A completes an application for enrollment through an FFM, makes a plan selection, and enrolls in QHP A with an effective date of February 1, 2015. Enrollee A pays his or her first month's premium on time, and the enrollee's coverage is effectuated for February 1, 2015. Enrollee B (who lives in the same state as Enrollee A) completes an application for enrollment through the same FFM, makes a plan selection, and also enrolls in QHP A with an effective date of February 1, 2015. Enrollee B pays his or her first month's premium on time, and the enrollee's coverage is effectuated for February 1, 2015. The issuer bills Enrollee A and Enrollee B for premiums in March and April 2015. Enrollee A and

Enrollee B pay in full. While generating the May 2015 billing invoices, the issuer's billing system malfunctions, causing the issuer to bill Enrollee A for May's premium while failing to bill Enrollee B. Enrollee A pays his or her premium for May 2015 coverage, but Enrollee B does not, since he or she did not receive a bill. The next month, the same malfunction occurs; Enrollee A pays the June 2015 premium and Enrollee B does not. The issuer realizes the billing problem while generating invoices for July 2015. Both Enrollee A and Enrollee B reside in State Z, which has retained primary enforcement authority. The State Z Department of Insurance instructs the issuer to forgo collection of Enrollee B's under-billed premium. As long as this policy is applied consistently and in a non-discriminatory manner, the issuer can forego collection of the under-billed premium related to Enrollee B's account, but it must report such uncollected premium to CMS as being earned/realized income for purposes of MLR, RC, and RA.

6.7.1 Collections and Grace Periods for Non-Payment of Under-Billed Premium

When an issuer identifies an amount of premium that has been under-billed, and attempts to collect such amounts, issuers are highly encouraged to allow affected enrollees a reasonable amount of time in which to pay such premium amounts, and should take steps to ensure that the time for repayment is adequate in light of the consumer's regularly-billed monthly premium amounts. QHP and QDP issuers are permitted to allow enrollees to pay under-billed premium in equal installments, in accordance with applicable state law. If a QHP or QDP issuer chooses to allow an enrollee to pay under-billed premium in equal installments, the issuer should provide the enrollee with documentation that clearly defines the amount of under-billed premium that the issuer will add to the regularly-billed monthly premium, as well as guidance informing the enrollee that if he or she does not pay all under-billed premium installments (as well as all regularly-billed monthly premiums) by the prescribed due dates, he or she will enter the applicable grace period.

The non-payment of under-billed premium amounts due is treated the same as the non-payment of regular monthly premium amounts with regard to grace periods and premium payment thresholds. Therefore, if an enrollee fails to pay any outstanding under-billed premiums to the QHP or QDP issuer by the date such amounts are due, he or she enters into the applicable grace period specified by 45 CFR §155.430 and 45 CFR §156.270. Upon triggering the grace period, the entire amount of outstanding under-billed premium must become due, if permitted by state law.

Examples

Example 6L: On January 5, 2015**,** an enrollee completes an application for enrollment through an FFM, makes a plan selection, and enrolls in QHP A with an effective date of February 1, 2015. The enrollee is eligible for, and elects to receive, APTCs. The portion of the monthly premium for which the enrollee is responsible is $100. The enrollee pays his or her first month's premium, and his or her coverage is effectuated for February 1, 2015. While generating the March 2015 billing invoices, the issuer's billing system malfunctions, causing the issuer to fail to

bill the enrollee for that month. The enrollee does not pay his or her March 2015 premium, since the enrollee did not receive a bill. The same malfunction occurs during the generation of the April, May, and June 2015 premium invoices; the enrollee does not pay his or her monthly premium for any of those months. The issuer uncovers the billing problem while generating invoices for July 2015 and informs the enrollee that the individual owes $400 (the under-billed premiums for the months of March, April, May, and June 2015), in addition to his or her normal monthly premium payment of $100 for July. The enrollee resides in State X, where the Department of Insurance directs the issuer to recoup the enrollee's under-billed premiums, starting with the July payment. The issuer allows the enrollee five months to repay the under-billed premiums, billing the enrollee $180 ($100 regular premium, plus $80 under-billed premium installment) for each of July, August, September, October, and November 2015. The enrollee pays $180 to the issuer each month from July 2015 through November 2015, and the issuer resumes billing the normal monthly premium amount ($100) for December 2015.

Example 6M: Same facts as Example 6L, except the enrollee is not eligible for APTCs as of July 1, 2015. Without APTCs, the enrollee's monthly premium is $200. The enrollee pays $280 for July 2015 coverage, but pays only $200 for August 2015 coverage. Pursuant to State X's rules, because the enrollee underpaid by $80 for August, he or she enters into a one-month grace period and termination of his or her coverage for non-payment of premiums would be retroactive to the last day his or her account was in good standing (July 31, 2015, in this example). To avoid termination of his or her coverage, the enrollee must pay the entire outstanding amount of under-billed premium ($320) before the end of State X's grace period. The enrollee pays the issuer $320 on August 28, 2015, and the issuer begins normal monthly premium billing for September 2015.

Example 6N: On January 5, 2015**,** an enrollee completes an application for enrollment through an FFM, makes a plan selection, and enrolls in QHP A with an effective date of February 1, 2015. The enrollee is eligible for, and elects to receive, APTCs, and his or her portion of the monthly premium for which he or she is responsible is $100. The enrollee pays the first month's premium, and coverage is effectuated for February 1, 2015. The issuer bills the enrollee normally for coverage in March 2015. The enrollee pays his or her $100 monthly premium in full. While generating the invoices for April 2015, the issuer realizes that the enrollee's premium has been rated incorrectly and that the proper monthly premium is $120. While the enrollee may be eligible for an SEP based on the error, he or she decides to remain enrolled in QHP A. The enrollee's new premium goes into effect with QHP A's April 2015 billing cycle. The enrollee resides in State Y, which directs the issuer to recoup the under-billed premium.

The issuer informs the enrollee of the discrepancy and, beginning with the April 2015 billing, allows the individual to pay two monthly installments of $20 in addition to the corrected premium payments of $120 to pay the under-billed premium and bring the account into good standing. The enrollee sends the issuer $120 for April 2015 coverage, but does not include a $20 under-billed premium installment. Although the enrollee paid the new regular monthly premium for April 2015 ($120), the enrollee did not pay the first under-billed premium installment. He or

she enters into a three consecutive month grace period on April 1, 2015, and must pay all additional regular monthly premium billed during the grace period ($120 for May 2015, and $120 for June 2015), and the outstanding under-billed premium amount ($40) by the expiration of the grace period to avoid termination for non-payment of premium. During the grace period, the enrollee pays the issuer a total of $240. At the end of the three consecutive month grace period, the enrollee still owes the issuer $40, since although he or she made sufficient payments to satisfy all regular monthly premiums billed during the grace period ($360), the enrollee did not remit the under-billed premium amount ($40). The issuer terminates the enrollee's coverage, retroactive to the last day of the first month of the grace period (April 30, 2015), for non-payment of premiums. The issuer will receive the enrollee's APTC for April 2015, and it may retain the premium the enrollee paid for April 2015, but it must return the APTCs paid on his or her behalf for May and June 2015, and refund the enrollee the premium he or she paid for May and June 2015 ($240).

Example 6O: Same facts as Example 6M, except the enrollee is not eligible for APTCs as of April 1, 2015. Here, the enrollee's monthly premium is $200. If the enrollee pays only $200 for April 2015 coverage, failing to include $20 for the under-billed premium installment, the enrollee enters a one-month grace period, starting on April 1, 2015, as determined by the rules of State. He or she must pay the amount of outstanding under-billed premium ($40) before the expiration of the grace period to avoid termination of his or her coverage. During the grace period, the enrollee makes no further payments. Although the enrollee paid the regular monthly premium of $200 for April 2015, the enrollee failed to pay the under-billed premium in full by the expiration of the grace period. As a result, the issuer may terminate his or her coverage.

6.7.2 Voluntary Termination of Coverage During Repayment of Under-Billed Premium

If an enrollee voluntarily terminates his or her coverage during the time he or she is paying under-billed premium installment payments, the enrollee's current QHP and/or QDP issuer can, if permitted by state law, accelerate payment by converting remaining installments, if any, into a lump sum payment due no earlier than the date the voluntary termination will take effect.

Examples

Example 6P: On January 5, 2015**,** an enrollee completes an application for enrollment through an FFM, makes a plan selection, and enrolls in QHP A with an effective date of February 1, 2015. The enrollee is eligible for, and elects to receive, APTCs, and the portion of the monthly premiums for which he or she is responsible is $100. The enrollee pays his or her first month's premium and coverage is effectuated for February 1, 2015. While generating the March 2015 billing invoices, the issuer's billing system malfunctions, causing the issuer to fail to bill the enrollee for that month. The enrollee does not pay the March 2015 premium, since he or she did not receive a bill. The same malfunction occurs in April, May, June, July, and August 2015; the enrollee does not pay the monthly premiums for any of those months. The issuer uncovers the billing problem while generating invoices for September 2015. The enrollee, who is a resident of

State W, owes the issuer $600 of under-billed premiums in addition to his or her normal monthly premium payments of $100. State W instructs the issuer to recoup the under-billed premiums, beginning with the September 2015 billing cycle. The issuer allows the enrollee three months to repay the under-billed premiums. The issuer informs the enrollee that it will bill the enrollee's $300 (normal monthly premium of $100 plus an under-billed premium installment payment of $200) for September, October, and November 2015 coverage. The enrollee pays the issuer $300 for coverage in September 2015. On September 14, 2015, the enrollee informs the issuer that he or she wishes to terminate coverage effective September 30, 2015. The issuer, in accordance with its billing policies and with the rules of State W, immediately bills for the remaining under-billed premiums ($400) in one lump sum, due on September 30, 2015, the date the voluntary termination will take effect. The enrollee receives the accelerated repayment schedule and pays the outstanding under-billed premiums.

Example 6Q: Same facts as Example 6P, but when the issuer bills the enrollee $400 for the under-billed premiums, due on September 30, 2015, the date the voluntary termination will take effect, the enrollee sends payment of $200 and makes no further payments. Since the enrollee's payment is insufficient to satisfy the outstanding amount of under-billed premiums, the issuer can pursue all options allowed under State W's laws to collect the remaining $200 from the enrollee.

6.8 TERMINATION OCCURING DURING A GRACE PERIOD

45 CFR §155.430 generally allows an enrollee voluntarily to terminate his or her coverage as of a date at least 14 days from the date he or she notified the Marketplace of his or her request to terminate coverage. If an enrollee seeks to voluntarily terminate coverage while he or she is in a grace period due to non-payment of premiums, the effective date of termination is the earlier of: (1) the enrollee's voluntary termination date, or (2) the date the enrollee's coverage is terminated for non-payment of premiums (involuntary termination date) if the enrollee fails to pay all outstanding premiums before the end of the applicable grace period.

Examples

Example 6R: An enrollee, who is receiving APTCs, enters a grace period on August 1, 2015, due to his or her non-payment of premiums. The grace period extends until October 31, 2015, and if the enrollee does not pay his or her outstanding premiums in full by that date, his or her coverage will terminate effective August 31, 2015, the last day of the first month of the grace period for enrollees receiving APTCs. On September 9, 2015, the enrollee accesses the FFM to voluntarily terminate his or her coverage because the enrollee has become eligible for and will begin receiving MEC through his or her employer effective October 1, 2015. Although he or she could request a termination date as early as 14 days from the date of his or her termination request, the individual requests a termination date of September 30, 2015. On September 9, 2015, the FFM sends an 834 transaction to the issuer with a termination effective date of September 30, 2015. The enrollee makes no further payments to the issuer. By the end of his or

her grace period (October 31, 2015), he or she has not paid all outstanding premiums to the issuer. On November 1, 2015, the issuer sends an 834 termination transaction to the FFM, changing the enrollee's effective date of termination to the date of involuntary termination for non-payment of premiums (August 31, 2015), instead of the voluntary termination date the enrollee requested (September 30, 2015). The issuer can reject any claims arising from medical service provided after August 31, 2015, and must return any APTCs paid on the enrollee's behalf for the period after August 31, 2015.

Example 6S: An enrollee, who is not receiving APTCs, enters a grace period for non-payment of premium on August 1, 2015. The law in the enrollee's state allows a one-month grace period to pay all outstanding premiums. If the enrollee does not pay all outstanding premiums during that one-month grace period, the issuer may terminate his or her coverage effective July 31, 2015, the last day the enrollee's account was in good standing. On August 10, 2015, the enrollee accesses the FFM to voluntarily terminate his or her coverage, effective August 24, 2015, because he or she will be receiving MEC through his or her employer. On August 10, 2015, the FFM sends an 834 transaction to the issuer, with a termination date of August 24, 2015. On the last day the enrollee's grace period, August 31, 2015, he or she has not paid the outstanding premium owed to the issuer. On September 1, 2015, the issuer sends an 834 to the FFM changing the enrollee's termination date to July 31, 2015, the date his or her coverage is being involuntarily terminated for non-payment of premiums.

6.8.1 Involuntary Termination Due to a Citizenship/Immigration Inconsistency Expiration During a Grace Period

An enrollee who is currently receiving coverage during a citizenship/immigration inconsistency period, and who does not pay monthly premiums, will enter the applicable grace period pursuant to 45 CFR §155.430 and 45 CFR §156.270. If the inconsistency expires during the grace period, the enrollee's coverage termination date will be the earlier of: (1) the date of the inconsistency expiration, or (2) the termination date associated with the applicable grace period.

Examples

Example 6T: An enrollee, who receives APTCs, is in a citizenship/immigration inconsistency period that will expire effective June 30, 2015, unless it is resolved earlier. The enrollee is also in a grace period ending on June 30, 2015, because he or she did not pay his or her April 2015 premium in full. As of June 30, 2015, the enrollee's inconsistency has not been resolved. Additionally, as of June 30, 2015, the enrollee has not paid the outstanding premium, and his or her coverage terminates effective April 30, 2015, per 45 CFR §155.430 and 45 CFR §156.270. The earlier of the two coverage expiration dates (termination for non-payment retroactive to April 30, 2015) applies.

6.8.2 Termination of APTCs during a Grace Period

If an enrollee receiving APTCs fails to pay premiums as they become due, the enrollee will receive a three consecutive month grace period, pursuant to 45 CFR §156.270(d). CMS interprets this grace period requirement as requiring the issuer to honor the three consecutive month grace period for an enrollee who was receiving APTCs when the enrollee entered the grace period, even if the enrollee's APTCs are terminated before the expiration of the grace period. In such cases, the enrollee's termination date also would adhere to the rules for an APTC grace period stated in 45 CFR §155.430(d)(4). We intend to propose an amendment to the regulation text in forthcoming rulemaking to explicitly reflect this interpretation.

Examples

Example 6U: An enrollee, who is receiving APTCs and is subject to a financial inconsistency, enters a grace period on August 1, 2015, due to his or her non-payment of premium. The grace period extends until October 31, 2015. On August 31, 2015, enrollee's financial inconsistency expires and the APTCs are adjusted to $0 by the FFM. Although the FFM will terminate the enrollee's APTCs effective September 1, 2015, the enrollee will have until October 31, 2015, to make full payment of all outstanding premium to avoid his or her coverage being terminated effective August 31, 2015, the last day of the first month of the grace period.

Example 6V: Same facts as Example 6U, but on September 14, 2015, after the enrollee's APTCs were terminated, the enrollee becomes eligible for an SEP, pursuant to 45 CFR §155.420(d)(6), because he or she has become newly eligible for APTCs. The enrollee completes an application on the FFM, makes a plan selection, and enrolls in QHP A, the same plan in which he or she was enrolled before and during the grace period, with an effective date of October 1, 2015. The enrollee pays the first month's premium on time, in accordance with 45 CFR §155.400(e)(1)(i), and the coverage is effectuated for October 1, 2015. On September 14, 2015, the FFM sends a termination/initial CIC transaction to the issuer with an 834 SEP reason code, showing a termination effective date of September 30, 2015. If the enrollee does not pay all outstanding premiums for August and September 2015 before October 31, 2015, the QHP A issuer will submit a termination transaction for non-payment, ending the enrollee's coverage on August 31, 2015, causing the enrollee to have a coverage gap from August 31, 2015 through September 30, 2015. In that case, the issuer may pursue any collection methods allowed in the enrollee's state to collect any outstanding premium from the enrollee's previous enrollment.

Example 6W: Same facts as Example 6V, but here the enrollee becomes eligible for an SEP on September 16, 2015, because he or she has become newly eligible for APTCs. The enrollee completes an application on the FFM, makes a plan selection, and enrolls in QHP A, the same plan in which he or she was enrolled before and during the grace period, with an effective date of November 1, 2015. The enrollee pays his first month's premium on time and coverage is effectuated for November 1, 2015. On September 16, 2015, the FFM sends a term/initial CIC transaction to the issuer with an 834 SEP reason code, showing a termination effective date of October 31, 2015. If the enrollee does not pay the outstanding premium before October 31, 2015,

the QHP A issuer will submit a termination transaction for non-payment, ending the enrollee's coverage on August 31, 2015, and causing the enrollee to have a coverage gap from August 31, 2015 through October 31, 2015. In that case, the issuer may pursue any collection methods allowed in the enrollee's state to collect any outstanding premium from the enrollee's previous enrollment.

6.8.3 Premium Paid to an Issuer Through a Third-Party

Any contract between an issuer and a third-party under which the third-party collects premium payments from enrollees and routes them to issuers is governed by state law. When the third-party payment vendor charges fees for its service, such as processing fees, in addition to the premium amount collected, issuers may not consider such fees to be part of the premium, and may not consider an enrollee's failure to pay the fees to be a non-payment of premium. Accordingly, if an enrollee's premium payment is routed to the issuer, the issuer cannot trigger applicable grace periods or terminate the enrollee's coverage for non-payment of fees. Rather, relationships between issuers and third-parties should be designed much like relationships in other commercial arenas where consumers may make in-person payments to vendors who will deliver their payment to a utility or other creditor, and require the consumer to pay any processing or transaction fee directly to the third-party before the third-party transmits the payment to the ultimate recipient. We encourage issuers to require that processing fees be delineated separately from the premium payment on any receipt or other evidence of the transaction.

7. TERMINATIONS (APPLICABLE TO INDIVIDUAL MARKET FFMS, SBM, QHP/QDP)

A termination is an end of an enrollee's coverage or enrollment in a QHP or QDP through the Marketplaces occurring after their coverage effective date. A termination may be either voluntary (i.e., initiated by the enrollee or the employer) or involuntary (i.e., initiated by the QHP/QDP or the FFMs). Issuers must notify the Marketplaces of involuntary terminations. If an enrollee's coverage or enrollment through the Marketplaces is terminated, the QHP or QDP must cover the enrollee and the covered services that the enrollee received, from the coverage effective date until the termination date.

The QHP/QDP issuer, or an FFM, can initiate an involuntary termination of an individual's coverage or enrollment through an FFM. A termination can be effective in the future (e.g., for a termination requested by the enrollee), or retroactively (e.g., if the enrollee died, or failed to pay premiums due by the end of a grace period). When an enrollee changes QHPs/QDPs, the termination of the enrollment through the Marketplaces in the initial QHP/QDP is effective the day before coverage in a different QHP/QDP becomes effective, even in cases of retroactive enrollment.

A Marketplace may establish operational standards for QHP and QDP issuers for implementing terminations, cancellations, and reinstatements. See 45 CFR §155.430 regarding terminations of enrollment through the individual market Marketplaces, and 45 CFR §155.735 regarding terminations of enrollments through the SHOPs, which are discussed above, in Section3.11, Terminations. The following are operational standards for the FFMs. For details regarding termination for non-payment of premiums, please refer to Section 6.3, Terminations for Non-Payment of Premium.

7.1 ENROLLEE REQUESTED TERMINATIONS

In accordance with 45 CFR §155.430(b)(1), enrollees have the right to terminate their coverage or enrollment in a QHP/QDP through a Marketplace provided they give adequate notice to both the FFMs and the QHP/QDP. Enrollees must request a voluntary termination of their coverage or enrollment through an FFM. An enrollee who voluntarily terminates coverage or enrollment through a Marketplace may select an effective date of termination at least 14 calendar days from the present date or at a later date within the plan year. However, after the termination is requested, the enrollee may contact the issuer to request that they effectuate termination sooner than 14 calendar days per 45 CFR §155.430(d)(2)(iii). The issuer has the discretion to grant the enrollee's request to terminate coverage or enrollment through the Marketplaces sooner than 14 days. CMS expects that the issuer's policy in this regard be applied uniformly to all enrollees. If an issuer is unable to accommodate the enrollee's request, the issuer should communicate that information to the consumer accordingly.

If an enrollee receiving APTCs who has paid at least one month's premium in full requests to terminate his or her coverage or enrollment in a QHP/QDP through a Marketplace during a three

month grace period and fails to pay all outstanding premiums in full by the end of the three month grace period, the termination date should be the earlier of the requested termination date or the termination date applicable under the grace period.

7.2 TERMINATION OF AN ENROLLEE IN THE FFMS DUE TO DEATH

Consumers who are enrolled through the FFMs or who are application filers should report the death of an enrollee through their HealthCare.gov account or by calling the Marketplace Call Center. This is important because the FFMs conduct redeterminations of eligibility consistent with 45 CFR §155.330 for the remaining members of the household. If a consumer or representative contacts the issuer directly, the issuer should provide the following directions:

- The termination of an enrollee's coverage due to death may be reported by an application filer. If the person taking action to terminate the deceased's coverage is the person who filed the application, they can do so online through HealthCare.gov and then contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) to report the date of death (otherwise the termination will be prospective only). Alternatively, an application filer can contact the Marketplace Call Center to both initiate the termination and report the date of death simultaneously. If the application filer does not have access to the online account, the termination of the deceased's coverage can only be initiated through the Marketplace Call Center. An individual who meets the definition of an application filer, as described in 45 CFR §155.20, will be allowed to update the application for the remaining members of the household if the deceased filed the application.

- If the consumer reporting the death is not an application filer, they must submit documentation of death to the FFMs. Consumers in this circumstance should submit documentation directly to the FFMs. Documentation may include a death certificate, obituary, power of attorney, proof of executor, or proof of estate. The documentation or an attached cover note should provide the following information:
    - Full name of the deceased
    - Date of birth of the deceased
    - FFM application ID (if known) of the deceased
    - SSN (if known) of the deceased
    - Contact information for the person submitting the documentation, including:
        - Full name
        - Address
        - Phone number

  All documentation should be mailed to:

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

The Marketplace Call Center will attempt to contact the individual who submits documentation of death regarding the termination of the deceased and reenrollment of any remaining enrollment group members. The remaining QIs or enrollees may need to update tax filing status, financial information, or other information on their FFM applications. These additional changes may qualify the remaining enrollees for SEPs.

When an enrollee's coverage is being terminated due to death, the issuer will receive the appropriate 834 enrollment transaction. The effective date generated by the FFM system will be prospective. The Marketplace Call Center will open a case in HICS, and assign the case to the issuer for retroactive termination (to be effective on the date of death). When applicable, the FFMs will also send an updated 834 transaction to reenroll any remaining QIs in coverage. The issuer may require additional steps to process the refund in accordance with state law.

The consumer who reports the death should contact the issuer regarding any applicable premium refunds or adjustments. Issuers should process premium refunds or adjustments in accordance with applicable law and existing industry practice.

7.3 AGING-OFF TERMINATIONS

State rules vary regarding the age until which issuers are required to allow an adult child to be covered as a dependent under the medical or 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. A state may not have a more restrictive rule. However, some states have more generous rules that allow certain individuals to remain covered as dependents beyond age 26 if additional criteria are met. Examples include place of residence, student status, disabled veteran status, marital status, or financial dependence. Information on specific states that extend the age limit beyond 26 is not included in this manual and must be obtained directly from the state's regulatory authority.

7.4 TERMINATIONS FOR FRAUD

Under 45 CFR §155.430(b)(2)(iii), the Marketplaces or the QHP or QDP issuer may terminate an enrollee's coverage if it is rescinded in accordance with §147.128. In such cases, a QHP or QDP issuer may terminate an enrollee's coverage through the Marketplaces if an enrollee performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact in connection with the enrollee's coverage, with at least 30 days advance written notice to each enrollee or participant affected by the intended termination. In addition, CMS requests that the issuer notify the Marketplaces of the rescission because of the effect it may have on an enrollee's subsidies.

In cases of fraudulent activity, the effective date of the termination may be retroactively applied if allowed by state law. Further, if state law allows, the QHP or QDP 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 or QDP issuer must return any premiums paid by the enrollee for the period after the retroactive effective date of termination, and CMS will recoup any APTCs or CSRs paid for that period, as well. In accordance with 45 CFR §156.270(b), the QHP or QDP issuer must provide the enrollee with proper notice of the termination. If a QHP issuer rescinds coverage for fraud, and in the next OEP the enrollee enrolls in the same QHP that was rescinded due to fraud, the issuer must accept the enrollment.

8. RETROACTIVITY (APPLICABLE TO INDIVIDUAL MARKET FFMS, QHP/QDP)

If an individual fulfilled all enrollment requirements, but, for some reason, the FFM or QHP/QDP issuer was unable to process the enrollment for the required effective date, the FFM (or designee) will process a retroactive enrollment effective date. If an enrollment was never legally valid, or if a valid termination request was properly made, but not processed or acted on by the FFM or the QHP/QDP, the FFM (or designee) will grant retroactive terminations. Retroactive transactions could have either an enrollment or a termination outcome. Retroactive effective dates can result from unforeseen life events, such as death; from FFMs or issuer error, such as incorrect data being manually entered from a paper application; or from an administrative process, such as an eligibility appeal decision. Many of the events and circumstances that result in retroactivity are addressed within regulatory rules on Terminations §155.430(d), Special Enrollment Periods §155.420(b), Redeterminations §155.330(f), and Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs §155 Subpart F. For more information on these topics please refer to Section 2.9, Redeterminations and Renewals in the FFMs, and Section 7, Terminations.

The retroactive enrollment or termination effective dates for these triggering events and circumstances are outlined in the respective sections of the regulations. There are exceptional circumstances that are not specifically addressed in the regulations. Those circumstances will be addressed on an individual basis, and determinations of outcomes will be decided by the FFMs in collaboration with issuers, when needed.

In most cases, issuers will receive an 834 transaction from the Marketplaces, which will communicate the correct retroactive enrollment or termination effective dates. However, in some cases (e.g., an eligible enrollee opts for retroactive effect of the appeal decision), CMS will notify the issuer(s) using HICS under certain circumstances, which will specify the effective date for the retroactive enrollment or termination and/or application of APTCs or CSRs amounts.

Unlike a reinstatement, which is a correction of records to “erase” an action, a retroactive enrollment is an action to enroll a QI into a QHP or QDP for a new time period. Reasons and effective dates for retroactive enrollments and terminations are outlined in Exhibit 29 and Exhibit 30. In some limited cases, CMS may determine that an individual is eligible for an SEP due to an extraordinary circumstance beyond the individual’s control and may also permit retroactive enrollment and termination as necessary.

Exhibit 29 – Retroactive Enrollment Reasons and Dates

Reason	Effective Date
Birth, Adoption, Placement for Adoption, or Placement in Foster Care	Date of Event
FFMs or QHP/QDP Issuer Error	Original Effective Date
Exceptional Circumstances	Date TBD by the FFM
Eligibility Appeals Outcome	Date TBD by Appeal Outcome

Exhibit 30 – Retroactive Termination Reasons and Dates

Reason	Effective Date
Death	Date of Event
Fraud	Variable
Exhausted Three Consecutive Month Grace Period	Last Day of First Month of Grace Period
Retroactive Medicaid/CHIP/Medicare/MEC	Day Before New Coverage Begins with Medicaid/CHIP/Medicare/MEC
FFMs or QHP/QDP Issuer Error	Original Effective Date
Exceptional Circumstances	Date TBD by the FFMs
Eligibility Appeals Outcome	Prospective or the Date the Incorrect Eligibility Decision was Made

Examples related to retroactivity are given in Exhibit 31.

Exhibit 31 – Retroactivity Examples

Family Composition	Action	Outcome
Subscriber, Spouse, and Two Dependent Children	Twin dependent children born on August 1. Newborn dependents are enrolled retroactively into the family's current QHP.	The FFM sends enrollment information for the group to the issuer. The issuer receives the transactions and confirms receipt of the transactions by sending an acknowledgement to the FFM. The issuer makes updates to their system. Coverage is effective August 1.

Family Composition	Action	Outcome
Subscriber and Spouse	Subscriber contacts FFM to inform them of spouse's sudden death three weeks prior.	The FFM terminates the deceased enrollee's coverage with a prospective termination date. The FFM then assigns a category 2 HICS ticket to the issuer requesting a retroactive termination date to be the effective date of death. The issuer may require additional steps to process the refund in accordance with state law.
Subscriber Only	Issuer sends termination transaction to FFM on October 31 for non-payment of premium for a subscriber that is receiving APTCs.	The FFM sends termination information for the subscriber to the issuer. The issuer receives the transaction and confirms receipt of the transaction by sending an acknowledgement to the FFM. The issuer makes updates to its system. The FFM then sends a notice to the subscriber regarding the termination of coverage. The retroactive termination date is August 31, the last day of the first month of the grace period.

Examples

Example 8A: An enrollee contacts the FFM on September 25 to inform the FFM of the birth of twins on September 1. 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 September 1.

Example 8B: An enrollee, who is the subscriber in the enrollment group, contacts the FFM on August 7, to report that his wife died three weeks earlier on July 14. As a result of his wife's death, the FFM representative informs the individual that he now qualifies for an SEP. The FFM confirms the date of death and assigns the issuer a category 2 HICS ticket requesting a retroactive termination date of July 14 for the coverage of the wife.

Example 8C: An enrollee receiving APTCs fails to fully pay his or her portion of the monthly premium due for August coverage (or fails to pay within the premium threshold if the issuer utilizes such). The three consecutive month grace period commences August 1. The enrollee fails to make any payments during the three months of the grace period. After October 31, the QHP issuer sends the FFM an 834 termination transaction for non-payment. Pursuant to the policy for retroactive terminations due to an exhausted three consecutive month grace period, the

retroactive termination effective date for this QHP is August 31, the last day of the first month of the grace period.

8.1 IMPLEMENTATION OF ENROLLEE REQUESTS FOR RETROACTIVE ELIGIBILITY

Pursuant 45 CFR §155.545(c), enrollees whose eligibility determination is found to be incorrect have the option to have the Marketplaces implement the appeal decision prospectively, on the first day of the month following the date of the appeal decision notice, or consistent with the effective dates provided under 45 CFR §155.330(f)(2) or (3), if applicable, or retroactively to the date the incorrect eligibility determination was made. In addition, the enrollee is granted a 60-day SEP beginning on the date of the appeal decision either to enroll in a QHP or switch QHPs.

In appeal decisions where the appellant opts for retroactivity, the issuer is responsible for:

- processing or re-processing, as applicable, the enrollee's claims incurred during the retroactive period;
- collecting premiums from the enrollee for months of retroactive coverage and providing a reasonable period of time for the enrollee to pay premiums for retroactive months of coverage; and
- in the case of retroactive changes to eligibility for APTCs or CSRs, refunding or crediting to the enrollee any excess cost sharing or premiums paid consistent with the previously released bulletins and in accordance with state regulatory authority.[25]

Issuers (including both the gaining QHP and the former QHP, if the enrollee opts to select a different QHP during the SEP that may be provided) will receive an 834 transaction from the Marketplaces, which will communicate the enrollee's corrected eligibility. In cases where an eligible enrollee opts for retroactive effect of the appeal decision, CMS will notify the issuer(s) using HICS, which will specify the effective date for the retroactive enrollment or termination and/or application of APTCs or CSRs amounts. The case narrative field in the HICS case will be populated as follows:

[25] See in particular, CMS Bulletin to Marketplaces on Availability of Retroactive Advance Payments of the PTC and CSRs in 2014 Due to Exceptional Circumstances (February 27, 2014); CMS Bulletin to Marketplaces on Availability of Retroactive Advance Payments of the PTC and CSRs in 2014 Due to Exceptional Circumstances, and Related SHOP Issues – Frequently Asked Questions (March 14, 2014); and Revised Bulletin #3 on HHS-granted Special Enrollment Periods for Federally-facilitated Marketplace and State Partnership Marketplace Issuers (March 26, 2014). All bulletins are available on REGTAP.

<Consumer name> has been granted retroactivity for plan enrollment and/or APTCs/CSRs amounts.
(If applicable) Retroactive enrollment date: [Insert effective date of retroactive enrollment].
(If applicable) Retroactive termination date: [Insert effective date of retroactive termination].
(If applicable) Monthly amount of APTCs and effective date: [Insert the amount of APTCs awarded and effective date of that amount].
(If applicable) Cost-Sharing Reductions and effective date: [Insert the CSRs level awarded and effective date of that CSRs level].

Consistent with 45 CFR §156.1010(d), issuers must take action to implement the appeal decision no later than 15 days after receipt of the HICS case, and, in cases of expedited appeals, within 72 hours after receipt of the HICS case, which will be designated as an urgent case in HICS. Finally, CMS intends to use the Enrollment Data Baseline and Enrollment Reconciliation processes to identify and resolve any enrollment discrepancies that could arise through use of HICS.

Exhibit 32 – Appeal Decision Scenarios Related to Retroactivity[26]

Appeals Outcome	Issuer Communication
Scenario #1. An applicant receives an appeal decision finding that the contested eligibility determination was incorrect. The applicant is not enrolled in a QHP and opts to have the enrollment implemented retroactively.	• The applicant chooses retroactive effectiveness and contacts the Marketplace to select a silver level QHP. • The issuer receives an 834 enrollment transaction and prospective enrollment effective date. • The applicant contacts the Marketplace Appeals Center, which generates a HICS case with a retroactive enrollment effective date, and if the appeal finds the applicant eligible for APTCs and CSRs, the monthly APTCs amount and CSRs level. • Upon receiving the HICS case, the issuer applies the retroactive effective date and, if applicable, the APTCs and CSRs, as provided in the HICS case, to the enrollee's enrollment from the 834 transaction, collects premiums, if applicable, for all months of retroactive coverage, and processes claims submitted by the enrollee or the enrollee's care providers for services furnished on or after the retroactive enrollment effective date.
Scenario #2. An enrollee receives an appeal decision finding that the contested eligibility determination was incorrect and that the enrollee should have been determined eligible for a higher level of APTCs and CSRs. The enrollee is currently enrolled in a silver level QHP, wishes to remain in that QHP, and opts to have the FFM implement the decision retroactively.	• The enrollee chooses retroactive effectiveness and contacts the Marketplace Appeals Center, which generates a HICS case with a retroactive enrollment effective date and monthly APTC amount and CSRs level. • Upon receiving the HICS case, the issuer applies the retroactive effective date and corrected APTCs and CSRs, as provided in the HICS case, to the enrollee's enrollment, refunding or crediting to the enrollee any excess premiums paid, reprocesses claims to account for the application of the higher level of CSRs, and refunds to the enrollee any excess cost sharing paid.

[26] Statements in these scenarios related to refunding premiums and cost-sharing and reprocessing claims are subject to applicable state regulatory authority.

Appeals Outcome	Issuer Communication
Scenario #3. An enrollee receives an appeal decision finding that the contested eligibility determination was incorrect and that the enrollee should have been determined eligible for APTCs or CSRs. The enrollee is currently enrolled in a non-silver level QHP and wishes to enroll retroactively in a silver level QHP offered by the same issuer.	• The enrollee chooses retroactive effectiveness and contacts the Marketplace to select a silver level QHP offered by the same issuer. • The gaining QHP receives an 834 enrollment transaction and prospective enrollment effective date. • The former QHP receives an 834 termination transaction with a prospective effective date. • The former QHP terminates the enrollee's coverage. • The enrollee contacts the Marketplace Appeals Center, which generates two HICS cases: one to the gaining QHP, which provides the retroactive enrollment effective date and APTCs and CSRs, and one to the former QHP, which provides the retroactive termination effective date. • The issuer reprocesses any claims submitted for services furnished to the enrollee, reversing the claims from the former QHP and processing them with the enrollee's corrected CSRs level under the gaining QHP. This should be done as if the claims had initially been submitted to the gaining QHP. • The issuer collects from the enrollee any premiums owed or refunds or credits to the enrollee any excess premiums or cost sharing paid.

Appeals Outcome	Issuer Communication
Scenario #4. An enrollee receives an appeal decision finding that the contested eligibility determination was incorrect and that the enrollee should have been determined eligible for APTCs or CSRs. The enrollee is currently enrolled in a QHP and wishes to enroll retroactively in a silver level QHP offered by a different issuer.	• The enrollee chooses retroactive effectiveness and contacts the Marketplace to select a QHP offered by a different issuer. • The gaining issuer receives an 834 enrollment transaction and prospective enrollment effective date. • The former issuer receives an 834 termination transaction with a prospective effective date. • The former issuer terminates the enrollee's coverage. • The enrollee contacts the Marketplace Appeals Center, which generates two HICS cases: one to the gaining issuer, which provides the retroactive enrollment effective date and APTCs or CSRs amounts, and one to the former issuer, which provides the retroactive termination effective date. • The former issuer repays premiums and reverses claims payments. • The gaining issuer collects premiums for all months of coverage and processes claims submitted by the enrollee or the care provider for services furnished on or after the retroactive enrollment effective date, accounting for the application of APTCs and CSRs.
Scenario #5. The enrollee receives an appeal decision finding that the contested eligibility determination was incorrect and that the enrollee should have been determined eligible for Medicaid. The enrollee wishes to terminate QHP coverage retroactively.	• The enrollee chooses retroactive effectiveness and contacts the Marketplace Appeals Center, which generates a HICS case indicating the retroactive termination effective date. • Upon receiving the HICS case, the former QHP terminates the enrollee's coverage. • The former issuer repays premiums, reverses claims payments, and refunds any cost sharing paid by the enrollee.

8.2 PREMIUM BILLED FOR A RETROACTIVE EFFECTIVE DATE

8.2.1 Effectuation with a Retroactive Coverage Effective Date

Pursuant to 45 CFR §155.400(e), a QI seeking coverage must pay the first month's premium before the applicable due date to effectuate coverage. In situations in which an individual seeks to enroll in coverage with a retroactive effective date, we interpret the requirement at 45 CFR §155.400(e) to pay the first month's premium to effectuate retroactive coverage as requiring

payment of the premiums for all months of retroactive coverage through the first prospective month of coverage subject to the issuer's payment threshold policy, if applicable. If the QI pays only the premium for one month of coverage, we interpret the regulation as providing for prospective coverage only. We intend to propose amendments to the regulation in forthcoming rulemaking to explicitly reflect this interpretation.

The retroactive coverage effective date is conveyed to the issuer via an 834 transaction

If a QI's retroactive coverage effective date is contained in an 834 transaction, the issuer must bill the QI for all premiums, including premiums for both retroactive and prospective coverage, in accordance with the effectuation rules enumerated in 45 CFR §155.400(e). If the QI makes a payment that is sufficient to pay all outstanding retroactive premiums, but insufficient to pay all regular monthly premiums or an amount satisfying the issuer's premium payment threshold (if applicable), the issuer must effectuate the QI's coverage with the earlier coverage date. However, the enrollee would enter into the applicable grace period and the enrollee would be required to pay all outstanding premiums due before the expiration of the grace period to avoid termination for non-payment, which would be effective in accordance with the applicable grace period requirements.

Examples

Example 8D: On June 10, 2015, the enrollee contacts the Marketplace Call Center to request an SEP pursuant to 45 CFR §155.420(d)(4). The enrollee informs the call center that although he or she was enrolled in QHP B with a coverage effective date of January 1, 2015, he or she should have been enrolled in QHP A instead. The call center sends his or her case to a member of the FFM casework team, who finds that the enrollee was enrolled in the wrong QHP. On July 1, 2015, the FFM sends the QHP B issuer a retroactive cancellation transaction. The QHP B issuer reverses the enrollee's submitted claims (excluding pharmacy claims) and refunds the premiums he or she paid for 2015 coverage. Also on July 1, 2015, the FFM sends the QHP A issuer an 834 transaction enrolling the enrollee with a coverage effective date retroactive to January 1, 2015. The enrollee's share of premium after applying his or her APTCs is $100 per month. The QHP A issuer receives the 834 transaction on July 2, 2015, and, pursuant to 45 CFR §155.400(e)(1)(iii), bills the enrollee for all prospective and retroactive premiums ($700 of premiums for retroactive coverage and $100 of premiums for August 2015), with a payment due date 30 calendar days from the date the issuer received the 834 transaction. Before the payment due date, the issuer receives payment of $800 from the enrollee, and effectuates his or her coverage retroactive to January 1, 2015.

Example 8E: Same facts as Example 8D, but before the due date, the enrollee pays the QHP A issuer $700 and makes no further payment. The issuer effectuates the enrollee's coverage retroactive to January 1, 2015, but enters a three consecutive month grace period due to his or her non-payment of premiums for August 2015. If the enrollee does not pay all outstanding

premiums before the expiration of the grace period, the issuer must terminate his or her coverage due to non-payment of premium in accordance with the requirements at 45 CFR §156.270(g).

A prospective coverage effective date is conveyed to the issuer via an 834 transaction, but the retroactive coverage date is conveyed in an associated HICS case.

If a QI's prospective coverage effective date is conveyed to the issuer via an 834 transaction and the retroactive coverage date via HICS. Based on timing of the receipt and processing of the associated HICS case, the issuer may have already billed the QI for the first month's premium in accordance with 45 CFR §155.400(e)(1)(i). If the QI pays the first month's premium, subject to the issuer's payment threshold policy, if applicable, the QI's enrollment would be effectuated for prospective coverage. If the QI does not make such a "binder payment," coverage would not be effectuated, either retroactively or prospectively.

Upon receipt of a HICS case directing an issuer to give an enrollee with effectuated coverage a retroactive coverage effective date, the issuer is expected to process the HICS case within a reasonable amount of time (CMS expects such processing to take no longer than 10 business days), and to bill the enrollee in compliance with state rules. In the absence of more generous state regulations, CMS encourages issuers to allow enrollees at least one full billing cycle in which to pay all outstanding retroactive premiums. If the issuer receives and processes the HICS case within a short time after receipt of the 834 transaction, and the QI's billing has not occurred, the issuer is encouraged to include the retroactive and prospective premium amounts on the same bill as though all information was conveyed to the issuer on an 834 transaction.

Examples

Example 8F: On March 10, 2015, the enrollee contacts the Marketplace Call Center to request an SEP pursuant to 45 CFR §155.420(d)(4) after he or she successfully appealed a previous determination, made on January 3, 2015, that he or she was not eligible for coverage. The enrollee selects QHP A, and an 834 transaction, with a coverage effective date of April 1, 2015, is sent to the QHP A issuer. The issuer bills the enrollee for April 2015 coverage (his or her premium is $100 after his or her APTCs are applied), the enrollee pays in full before the issuer's due date, and his or her coverage is effectuated for April 2015. After the FFM sends the issuer the 834 transaction, the FFM sends a HICS case to the issuer instructing the issuer to give the enrollee a coverage effective date of February 1, 2015, the date he or she would have received coverage if his or her initial eligibility determination had been correct. The issuer promptly processes the HICS case and bills the enrollee $200 (premium for February and March 2015). The enrollee pays in full before the issuer's due date. The enrollee's coverage effective date is changed from April 1, 2015, to February 1, 2015.

Example 8G: Same facts as in Example 8F, but here the enrollee does not make a payment sufficient to satisfy the premiums owed for retroactive coverage for February and March 2015.

Although the enrollee effectuated prospective coverage for April 2015, he or she will not receive the earlier coverage effective date of February 1, 2015.

Example 8H: Same facts as in Example 8F, but here the issuer received and processed the HICS case soon after receiving the 834 transaction and before the enrollee has been billed. The issuer should bill the enrollee $300 (premiums for February and March 2015) and $100 (premium for April 2015). The enrollee pays in full before the issuer's due date. His or coverage is effectuated for February 2015, and his or her account is in good standing.

8.2.2 Retroactive Premium Owed by an Effectuated Enrollee

If an enrollee with an effectuated enrollment is awarded a retroactive coverage effective date, the enrollee must pay all outstanding retroactive premium by the later of: (1) the time period mandated by state rules, or (2) the issuer's stated due date. In the absence of more generous state regulations, CMS encourages issuers to allow at least one full billing cycle for enrollees to make such a payment of retroactive premium. If an enrollee does not pay all outstanding retroactive premium before the applicable due date, the enrollee would not receive an earlier coverage date. Billing statements should clearly differentiate between premiums for retroactive coverage and premiums for prospective coverage. If, by the applicable due date, an enrollee submits payment that satisfies the amount owed for regular monthly premiums, but not the amount owed for the entirety of the retrospective coverage, the issuer should consider the payment to have been for prospective coverage and refund any overage or credit the enrollee's account toward future billings.

Examples

Example 8I: An enrollee visits HealthCare.gov and completes an application on January 3, 2015, but is determined to be ineligible. On March 10, 2015, and pursuant to an SEP, the enrollee revisits HealthCare.gov, is determined eligible, and later effectuates with QHP B for April 2015. The enrollee's regular monthly premium is $100 after the application of APTCs. The enrollee appeals his or her January eligibility determination and, on May 5, 2015, he or she receives an appeal finding that he or she should have been determined eligible in January 2015. The FFM sends the QHP B issuer a HICS case, which the issuer processes promptly. The enrollee must pay the entire amount of retroactive premium for February and March 2015 ($200), which the issuer adds to the enrollee's next regular monthly premium bill ($100) for coverage effective February 1, 2015. The enrollee pays $300 before the due date and receives the retroactive coverage effective date.

Example 8J: Same facts as in Example 8I, but instead of paying $300 to the QHP B issuer when billed for retroactive (February and March 2015) and prospective coverage, the enrollee pays a total of $200 before the due date. Since this amount is not sufficient to satisfy all outstanding retroactive and prospective coverage, the issuer should contact the enrollee to ask if he or she would like the payment applied to his retroactive or prospective coverage. If the enrollee's

payment is applied to the retroactive coverage, then the enrollee would receive the earlier coverage effective date (February 1, 2015), but he or she would enter a grace period for non-payment of premiums. If the enrollee's payment is applied to his or her prospective coverage, the enrollee does not receive the earlier coverage effective date and the issuer must either credit the overage ($100) to the enrollee's future billing or refund it to him or her in full.

Example 8K: Same facts as in Example 8I, but instead of paying $300 to the QHP B issuer when billed for retroactive (February and March 2015) and prospective coverage, the enrollee pays a total of $100 before the due date. Since this amount is not sufficient to satisfy all outstanding retroactive premiums, the QHP B issuer would apply the enrollee's payment to his or her prospective coverage and the enrollee will not receive the earlier coverage effective date.

8.3 PAYMENT DUE DATES FOR RETROACTIVE EFFECTIVE DATES

If a QI enrolls in a QHP or QDP but is entitled to a retroactive coverage date, the QI must pay all retroactive premium within the greater of: (1) one billing cycle, or (2) the payment period required by state law in order for the enrollee to effectuate the earlier coverage date. If the enrollee does not make a payment sufficient to satisfy all retroactive premiums, the enrollee's coverage would not effectuate, either retroactively or prospectively. If the enrollee makes a payment sufficient to pay all retroactive premiums, but not to pay for the upcoming month's coverage, the enrollee's coverage effectuates retroactive to the date to which the enrollee is entitled. The enrollee immediately enters into the applicable grace period with regard to prospective coverage. If the enrollee makes a payment sufficient to pay all retroactive premiums and the premium for the upcoming month, coverage is effectuated retroactive to the date to which the enrollee is entitled and prospective coverage is billed normally.

9. REINSTATEMENTS (APPLICABLE TO INDIVIDUAL MARKET FFMS, QHP/QDP)

A reinstatement is the undoing of a termination or cancellation, and results in restoration of an enrollment to the original coverage effective date with no break in coverage. Some common reasons for reinstatements are:

- Erroneous Termination/Cancellation of an Enrollment by an Issuer
- Erroneous Termination/Cancellation of an Enrollment Initiated by an A/B
- Erroneous Death Notification
- Marketplace Error
- Assister Error
- Enrollee Cancellation of a New Enrollment

9.1 REINSTATEMENTS IN THE FFMS

The FFMs do not have functionality to transmit 834 reinstatement transactions to the issuer in an automated fashion. Issuers are able to transmit 834s to the FFMs to reinstate an enrollment record. To reinstate an enrollment record, the issuer must remove the cancellation or termination date from the enrollment in the issuer's internal systems. The issuer will reactivate the enrollment as if it were never terminated or cancelled, and provide coverage based on the original effective date, maintaining all out-of-pocket accumulators. The issuer will transmit the 834 reinstatement transaction to the FFMs within five calendar days of the determination for reinstatement.

9.1.1 Premium Payment for Reinstatements

Since reinstatements are not initial enrollments, issuers are encouraged to allow at least 10 working days after receipt of the 834 transaction for payment of all outstanding premiums.

9.1.2 Reinstatements Due to Mistaken Disenrollment Due to Issuer Error

When an erroneous termination or cancellation is the result of issuer error, the issuer must reinstate the enrollment group and restore the enrollment in its records. The issuer can reinstate the enrollment group's enrollment through the Marketplaces without Marketplace approval or intervention in these circumstances.

9.1.3 Reinstatements Due to Mistaken Disenrollment Due to A/B Error

When an erroneous termination or cancellation is the result of A/B error, CMS encourages the issuer to reinstate the enrollment group's enrollment through the Marketplaces. The issuer can reinstate the enrollment group's enrollment through the Marketplaces without Marketplace approval or intervention in these circumstances.

9.1.4 Reinstatements Due to Mistaken Disenrollment Due to Erroneous Death Notification

When a termination or cancellation is the result of erroneous death notification, the issuer is encouraged to reinstate the enrollment group's enrollment through the Marketplaces, but this action requires Marketplace approval. The issuer will receive approval for reinstatement from the Marketplace via a HICS case, Account Manager, or other means, when the Marketplace determines the termination based on death was in error. The issuer should then reinstate the enrollment group's enrollment through the Marketplace based on the guidance provided by the Marketplaces.

If the enrollee calls the issuer to state they are not deceased and their enrollment through the Marketplace was terminated in error, the enrollee must call the Marketplace for assistance to have coverage through the Marketplace reinstated. The issuer cannot reinstate the enrollee's enrollment through the Marketplace for erroneous death at the request of the enrollee directly.

9.1.5 Reinstatements Due to Mistaken Disenrollment Due to Marketplace or Assister Error

When an erroneous termination or cancellation is the result of a Marketplace or assister error, the Marketplace will notify the issuer that the termination or cancellation was erroneous and instruct the issuer to reinstate the enrollment group's enrollment through the Marketplace. The issuer is encouraged to reinstate the enrollment group's enrollment through the Marketplace based on the guidance provided by the Marketplace. If enrollees call an issuer to state their enrollment through the Marketplace was terminated in error, the issuer should work with its CMS Account Manager or Lead Caseworker to obtain approval to reinstate the enrollment record.

9.1.6 Reinstatements Due to Mistaken Disenrollment Due to Enrollee Cancellation of a New Enrollment

In cases where an enrollee's enrollment is terminated because the enrollee selected a different plan, but then the enrollee cancels the selection of the new plan and the enrollee wants to remain in the previous QHP, the enrollee may want to have the enrollee's enrollment reinstated. If the enrollee contacts the previous issuer requesting reinstatement, the issuer must confirm that the enrollee successfully cancelled the enrollment in the new QHP by requesting confirmation from the enrollee. If the enrollee is unable to provide evidence of the cancellation, the issuer should work with its CMS Account Manager or Lead Caseworker to verify successful cancellation of the enrollment in the new plan. Once the cancellation is confirmed, the issuer is encouraged to reinstate the enrollee's enrollment through the Marketplace.

The above guidance pertaining to reinstatements is summarized in Exhibit 33.

Exhibit 33 – Summary of Reinstatements in the FFMs

Reason for Reinstatement	Marketplace Approval Needed?	Outcome
Issuer Error	No	Issuer must reinstate enrollment group and restore enrollment.
A/B Error	No	Issuer can reinstate enrollment group and restore enrollment.
Erroneous Death Notification	Yes. Issuer cannot reinstate enrollee for erroneous death notification at the request of enrollee directly. If enrollee calls issuer to state they are not deceased and enrollment was terminated in error, enrollee must call the Marketplace for assistance.	Issuer will receive approval for reinstatement when the Marketplace determines the termination based on death was in error. Issuer should reinstate enrollment group and restore enrollment based on guidance provided by the Marketplace.
Marketplace/Assister Error	Yes. If enrollee calls issuer to state enrollment was terminated in error, enrollee should be directed to the call center.	Issuer should reinstate the enrollee's enrollment when the Marketplace determines that the termination or cancellation was erroneous and sends instruction to the issuer.
Enrollee Cancellation of New Enrollment	Yes. The enrollee should contact the Marketplace to have coverage reinstated.	Issuer is encouraged to reinstate the enrollee's enrollment when the issuer determines enrollee successfully cancelled enrollment in "new" QHP.

CMS expects QHP issuers to be enrollees' first point of contact for many types of issuer-related matters. As such, when CMS has promulgated policy or guidance, such as in this document, issuers can follow that policy to advise or assist the consumer as appropriate, and note the necessary changes in their internal contact management and enrollment systems. Consumers should only be directed to the Marketplaces for matters the issuer is unable to or not permitted to address without Marketplace action.

10. ENROLLMENT RECONCILATION (APPLICABLE TO INDIVIDUAL MARKET FFMS, QHP/QDP)

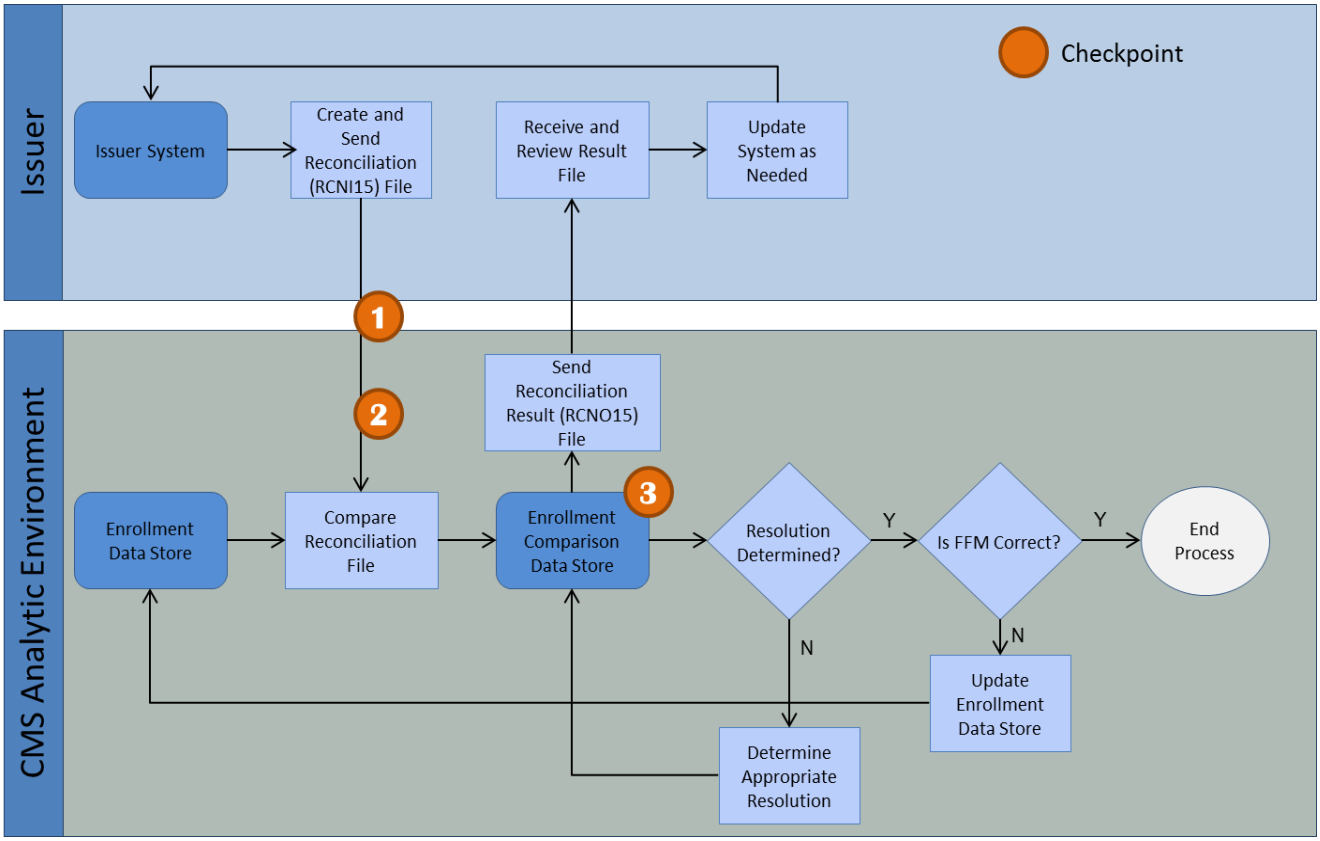
Pursuant to 45 CFR §155.400(d), the FFMs are required to reconcile enrollment records with all participating issuers on a monthly basis. Reconciliation ensures that QHP issuers, QDP issuers, and the Marketplaces have equivalent enrollment information. Accurate enrollment information allows CMS to make correct payments for APTCs and CSRs, and to assess FFM user fees. It also prevents multiple enrollments by one individual and ensures that the data used for analytics and metrics are accurate.

10.1 ENROLLMENT DATA RECONCILIATION PROCESS

When QIs enroll in coverage through an FFM or make changes to their coverage, the FFM sends an enrollment transaction to the relevant issuer. To ensure the accuracy and completeness of the information transmitted and to maintain consistent information between issuers and the FFMs, a process called enrollment data reconciliation is used. At least monthly, issuers and the FFMs will exchange enrollment and financial data files to verify the integrity of the enrollment transaction processing and resulting records. The FFMs employ an automated monthly reconciliation process comparing certain data fields with issuer data.

Exhibit 34 provides a high-level overview of the process involved to complete monthly enrollment data reconciliation between QHP and QDP issuers and the FFMs.

Exhibit 34 – High-level Reconciliation Approach



10.1.1 Pre-Audit File

At least monthly, the FFMs will send issuers a "snapshot" of their current enrollment data in the form of a pre-audit file. Issuers use the pre-audit files to compare the information in their system with the FFM data and identify any missing enrollments.

10.1.2 Submission of Issuer Audit Files to the FFMs

Issuers create inbound reconciliation files with their enrollment data to submit to the FFMs. The inbound reconciliation data includes information about current enrollees, cancelled enrollment records, and terminated enrollments. The inbound files include both enrollment and financial data elements. Upon receiving the inbound reconciliation files from issuers, CMS compares the issuers' data to the FFMs' data through the use of a reconciliation tool.

After issuers submit their inbound reconciliation files, an analytics contractor performs an automated data match between the issuer submitted files and the FFM enrollment data. The automated process matches records based on a unique collection of field information and resolves discrepancies through automated "rules." In cases where records cannot be matched, the records are flagged to send to the Enrollment Resolution & Reconciliation (ER&R) contractor to research and resolve. Through an issuer dispute process, issuers may dispute data elements

resolved through the automated process with which they disagree by sending disputes directly to the ER&R contractor for research and resolution.

10.2 RESOLUTION OF ENROLLMENT DISCREPANCIES

The ER&R contractor is responsible for resolving discrepancies that cannot be resolved through the automated reconciliation process. As such, the ER&R contractor will resolve any remaining discrepancies between FFM data and the issuer data.

Following the resolution of any ER&R discrepancies, either generated from the automated process or from issuer disputes, the ER&R contractor will submit changes to the FFMs or issuers to update their respective data.

10.2.1 Updating Incorrect Enrollment Data

Depending on the results of the automated reconciliation process or the ER&R contractor work, there are instances where the FFMs' records are updated through a Batch Utility Update (BUU) process or data clean-up, and other times when the issuer is expected to update its records. Every update sent to the FFMs through the BUU process is validated by an independent quality assurance contractor. Every BUU run is performed in a replicated production environment and results are evaluated prior to execution in production. Additionally, data clean-up scripts are validated in replicated production environment where possible prior to execution in production. CMS makes a formal go/no-go decision for any BUU or clean-up run prior to execution in production.

Through the reconciliation process, APTCs, advance CSRs amounts, and their effective dates are compared and expected to match, but payment amounts are not altered. Upon the implementation of the automated policy-based payment process, any changes to APTCs and advance CSRs amounts, or to their associated effective dates that occur through reconciliation will be paid by CMS or recovered from the QHP issuers in the first monthly payment cycle following the update of the FFMs through BUU or data clean-up.

APPENDIX A – SAMPLE WELCOME LETTER

Birchwood Health Plan

[Date]

[Insert name]
[Insert address]

Dear [Insert name],

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	[Date]
Adam Klein	Birchwood Health Plan	[Date]

Benefits may change from year to year. You will be notified of these changes before the Open Enrollment Period (OEP). You can change plans during the OEP.

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 OEP.

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 ET, and Saturday and Sunday from 9am-5pm ET.

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 ET, and Saturday and Sunday from 9am-5pm ET.

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 B – SAMPLE NON-PAYMENT NOTICE FOR THE INDIVIDUAL MARKET

Birchwood Health Plan

[Date]

[Insert name]
[Insert address]

Dear [Insert name]:

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 [month] in the amount of $155.00 by [the due date].

Because you are getting advance payments of the premium tax credit to help pay for your insurance, you have a 3-month grace period to pay your outstanding premium and any new premiums that accrue during this period before your insurance coverage will end. Your grace period starts on [date] and will end on [date].

What happens if I do not pay my premium?

If you do not pay your [month] premium by the end of the grace period (as well as any additional premiums that become due between now and when you pay), your enrollment in Birchwood Health Plan will be terminated back to [date]. If you wait until the final day to make to make any payment, the total amount will be due on that day.

What happens if my coverage ends?

If your coverage ends, you may be responsible for the cost of health services received after your last day of coverage, [date], and, if you are not eligible for a special enrollment period, you may not be able to enroll in another health insurance plan through the Marketplace until the next annual open enrollment period. Also, you or another taxpayer who claims you as a tax dependent may owe a penalty when filing an annual federal income tax return for the year, if you have gaps in qualifying health coverage of three months or more during the year or do not qualify for another exemption.

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

You can select a qualified health plan for enrollment through the Marketplace during the next annual open enrollment period.

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, or have a child), your income, or if you move, you may be eligible for a special enrollment period to enroll in coverage before the annual open enrollment period. You will need to tell the Marketplace if you experience any changes, and they will tell you if you are eligible 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 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 ET, and Saturday and Sunday from 9am-5pm ET.

Sincerely,

Birchwood Health Plan
23 West Drive, Suite 300
Jacksonville, FL 32202
[Insert privacy disclosure language]

APPENDIX C – SAMPLE TERMINATION LETTER

Birchwood Health Plan

[Date]

[Insert name]
[Insert address]

Dear [Insert name],

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 August 31, 2015, because you requested that Birchwood terminate your insurance. You requested to terminate your insurance by calling our help desk on July 20, 2015.

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	August 31, 2015	Requested to terminate coverage
Linda Allen	Birchwood Health Plan	August 31, 2015	Requested to terminate coverage

What happens when my coverage ends?

If you terminate your coverage and do not get other health coverage, you may be fully responsible for the cost of health services that you receive after you are disenrolled from your plan. If you are not eligible for a special enrollment period, you may not be able to enroll in another health insurance plan through the Marketplace until the next annual open enrollment period. Also, you or another taxpayer who claims you as a tax dependent may owe a penalty when filing an annual federal income tax return for the year if you have a gap in health coverage of three months or more during the year or do not qualify for another exemption.

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

You can select a qualified health plan through the Health Insurance Marketplace at www.HealthCare.gov during the next annual open enrollment period.

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, or have a child), your income, or if you move, you may be eligible for a special enrollment period to enroll in coverage before the annual enrollment period. You need to tell the Health Insurance Marketplace if you experience any changes, and they will tell you if you are eligible 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. For more information, visit www.HealthCare.gov.

What if I think there's 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 ET, and Saturday and Sunday from 9am-5pm ET.

Sincerely,

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

[Insert privacy disclosure language]

APPENDIX D – MANDATORY ATTESTATION

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

Advance Payments of the Premium tax credit attestations

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

I understand that because advance payments of 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, unless an exception applies.

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 of the premium tax credit for which I am the applicable taxpayer.

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 household income on my tax return with the household income on my application. I understand that if the household 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.