Federally-facilitated Exchange (FFE) Enrollment Manual

This manual is effective as of October 1, 2026. All enrollments made on or after this date should be processed in accordance with the operational requirements set forth in this document.

CMS intends to update this manual regularly. All previous versions of this manual and bulletins that have been incorporated into this version should be considered superseded by this manual. If you have questions related to content posted within this manual, please email CMS_FEPS@cms.hhs.gov.

REVISION HISTORY

Section	Description of Change
3	Additional information on Batch Auto Re-enrollment transactions
6	Edits throughout to clarify premium payment and grace period rules
7	Clarification of the requirements for sending termination notices
8	Updates to clarify when issuers may reinstate coverage
12	Updates to communicate policy changes for unauthorized enrollments and clarification of the rescissions standard

NOTE: This is not an exhaustive list of all updates from the previous version of the manual.

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1. INTRODUCTION AND SCOPE

1.1 Background

The Patient Protection and Affordable Care Act (ACA) (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 ACA, was enacted on March 30, 2010. The statute has been updated periodically since, including provisions changed by the American Rescue Plan Act of 2021 (Pub. L. 117-2). In this manual, the law is referred to collectively as the ACA. The ACA created private Health Insurance Exchanges (also referred to as Marketplaces) that enable qualified individuals (QIs) to shop for, select, and enroll in quality, affordable private health plans from competing health insurance issuers. The Exchanges also allow individuals to obtain eligibility determinations or eligibility assessments for coverage under Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP), where applicable. In addition, the ACA created Small Business Health Options Program (SHOP) Exchanges 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 Exchanges since October 1, 2013, for coverage beginning January 1, 2014.[1]

1.2 Types of Exchanges

The Exchanges (or Marketplaces) established by the ACA are established in one of several different ways, including as a:

- **State-based Exchange (SBE)**: A state that elected to establish its own Exchange operates an SBE.
- **Federally-facilitated Exchange (FFE)**: Pursuant to Section 1321(c)(1) of the ACA, the Federal government established an FFE in any state that did not elect to establish an SBE or in a state that the Secretary of the Department of Health & Human Services (the Secretary) determined would not have an operable Exchange.
- **State-based Exchange on the Federal Platform (SBE-FP)**: An SBE-FP uses the Federal eligibility and enrollment platform operated by the FFE to perform eligibility and enrollment functions. As such, the information in this manual is applicable to SBE-FPs and issuers participating in SBE-FPs in accordance with 45 CFR 155 Subpart E. SBE-FPs are directly responsible for performing certain Exchange functions, including certification of Qualified Health Plans (QHPs) and consumer assistance such as Medicaid/CHIP consumer support in coordination with their respective state Medicaid/CHIP agency (by phone, website, and the Marketplace Call Center).
- **State-based Small Business Health Options Program (SB-SHOP)**: An SB-SHOP is a type of SBE designed to assist qualified employers with facilitating the enrollment of their employees in QHPs offered in the small group market.
- **Federally-facilitated Small Business Health Options Program (FF-SHOP)**: An FF-SHOP is a type of FFE designed to assist qualified employers with facilitating the enrollment of their employees in QHPs offered in the small group market.

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

1.3 Purpose of Document

This manual provides operational policy and guidance on key topics related to eligibility and enrollment within the FFE, as well as within the SBE-FPs, which use the Federal platform to perform their eligibility and enrollment functions. For ease of reference, this document will use the term "FFE" to refer to all individual market Exchanges that rely on the Federal eligibility and enrollment platforms.

Where necessary, CMS will indicate when the guidance pertains to both QHPs and Exchange-certified stand-alone dental plans, which this manual refers to as Qualified Dental Plans (QDPs).

The information provided in this document applies to organizations and entities that may be involved in or assist with enrolling QIs into a QHP or QDP using the FFE's eligibility and enrollment functions. These entities include:

- SBE-FPs and issuers participating in the SBE-FPs.
- QHP and QDP issuers.
- Agents or brokers (A/Bs), including web-brokers, who are registered with the FFE.
- Navigators, Certified Application Counselors (CACs), and caseworkers.
- Third-party administrators (TPAs) of QHPs, QDPs, or employer-sponsored coverage.
- Trading partners of QHP and QDP issuers, such as healthcare clearinghouses.

1.4 Acronyms

Exhibit 1 describes commonly used acronyms and terms that appear throughout this document.

Exhibit 1: Commonly Used Acronyms

Acronyms	Descriptions
A/B	Agent or Broker
ACA	Affordable Care Act
AMRC	Additional Maintenance Reason Code
API	Application Programming Interface
APTC	Advance Payments of the Premium Tax Credit
AT	Account Transfer
BAR	Batch Auto Re-enrollment
BHP	Basic Health Program
CAC	Certified Application Counselor
CCIIO	Center for Consumer Information & Insurance Oversight
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CIC	Change in Circumstance

Acronyms	Descriptions
CMP	Civil Money Penalty
CPI	Center for Program Integrity
CSR	Cost-Sharing Reduction
DCW	Data Correction Window
DE	Direct Enrollment
DMI	Data Matching Issue/Inconsistency
DOB	Date of Birth
DSH	Data Services Hub (Hub)
EAPS	Enrollment Alignment Performance Summary
EDA	Enrollment Data Alignment
EDE	Enhanced Direct Enrollment
EDI	Electronic Data Interchange
EDN	Eligibility Determination Notice
EDS	External Data Source
EFT	Electronic Fund/File Transfer
EHB	Essential Health Benefits
EOY	End-of-Year
ER&R	Enrollment Resolution and Reconciliation
ET	Eastern Time
FEMA	Federal Emergency Management Agency
FFE/FFM	Federally-facilitated Exchange/Marketplace
FF-SHOP	Federally-facilitated Small Business Health Options Program
FPL	Federal Poverty Level
FTR	Failure to File and Reconcile
HCRP	High-Cost Risk Pool
HHS	Department of Health & Human Services
HICS	Health Insurance Casework System
HIOS	Health Insurance Oversight System
HIPAA	Health Insurance Portability and Accountability Act of 1996

Acronyms	Descriptions
HRA	Health Reimbursement Arrangement
ICHRA	Individual Coverage Health Reimbursement Arrangement
IRS	Internal Revenue Service
MAGI	Modified Adjusted Gross Income
MEC	Minimum Essential Coverage
MIE	Misaligned Issuer Enrollment
MLR	Medical Loss Ratio
MOEN	Marketplace Open Enrollment Notice
MRC	Maintenance Reason Code
MSD	Marketplace Service Desk
MTC	Maintenance Type Code
NPN	National Producer Number
OEP	Open Enrollment Period
PBP	Policy-Based Payment
PCL	Plan Category Limitations
PDI	Post-Deadline Inaccuracy
PDM	Periodic Data Matching
PM	Plan Management
PO	Production Operations
PTC	Premium Tax Credit
QDP	Qualified Dental Plan
QHP	Qualified Health Plan
QI	Qualified Individual
QSEHRA	Qualified Small Employer Health Reimbursement Arrangement
RA	Risk Adjustment
RADV	Risk Adjustment Data Validation
RCNI	Reconciliation Inbound
RCNO	Reconciliation Outbound
SBE	State-based Exchange (operating its own platform)

Acronyms	Descriptions
SBE-FP	State-based Exchange on the Federal Platform
SB-SHOP	State-based Small Business Health Options Program
SEED	System of Exchange Enrollment Data
SEP	Special Enrollment Period
SLCSP	Second Lowest Cost Silver Plan
SOP	Standard Operating Procedure
SSA	Social Security Act
SSN	Social Security Number
TPA	Third-Party Administrator
UE	Unauthorized Enrollment
UIE	Unaffiliated Issuer Enrollment
UIR	Unmatched "I" Record
UPS	Unauthorized Plan Switch

1.5 Definitions

Accumulators: Accumulators are metrics such as deductibles or maximum out-of-pocket limits that determine how much of the medical costs covered by the plan that an enrollee must pay before the plan pays or the plan payment amount changes.

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

Agent or Broker (A/B): A person or entity licensed by the state as an agent, broker, or insurance producer, as 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 Re-enrollment (Passive): Auto re-enrollment is an enrollment transaction that automatically continues coverage in the individual market FFE for the new plan year for an enrollee who does not actively select a plan for the new plan year by the regular deadline for plan selections for January 1 coverage, without a lapse in coverage, if timely premium payment is made.

Batch Auto Re-enrollment (BAR): BAR is the process the individual market FFE uses to implement auto re-enrollment.

Cancellation: A cancellation is a specific type of termination action that ends a qualified individual's enrollment through the Exchange on the date such enrollment became effective resulting in enrollment through the Exchange never having been effective.

Consolidated Omnibus Budget Reconciliation Act (COBRA): COBRA is Federal legislation that amended the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986 (the Code), and the Public Health Service Act 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 group health plan coverage at group rates. COBRA continuation coverage, however, is available only when coverage under the group health plan is lost due to specific qualifying events.

Cost-Sharing Reduction (CSR): CSR has the meaning set forth in 45 CFR 155.20.

Data Matching Issue/Inconsistency (DMI): When an application filer provides information to the Exchange as a part of the application process and the Exchange is unable to verify the information according to regulations and guidance, a DMI results. The application filer needs to resolve DMIs related to citizenship or immigration within 95 days and all other DMIs within 90 days. Otherwise, the enrollee's enrollment through the Exchange may be terminated and/or the enrollee's APTC and CSR may be terminated or adjusted, if applicable.

Deductible: A deductible is the amount an enrollee must pay for covered healthcare services before the plan starts to pay. Once the deductible is met, enrollees generally must pay only a copayment or coinsurance for covered services.

Direct Enrollment (DE) Entity: An entity that an Exchange permits to assist consumers with direct enrollment (including both classic DE and enhanced DE (EDE)) in QHPs offered through the Exchange in a manner considered to be through the Exchange as authorized by 45 CFR 155.220(c)(3), 155.221, or 156.1230, and as defined in 45 CFR 155.20.

DE Technology Provider: A provider of technology services on behalf of QHP issuers or web-brokers to facilitate their participation in DE under 45 CFR 155.220(c)(3), 155.221, and/or 156.1230, as applicable. An A/B DE technology provider, as defined in 45 CFR 155.20, is a type of web-broker business entity that is not a licensed A/B under state law and has been engaged or created by or is owned by an A/B to provide technology services to facilitate participation in DE under 45 CFR 155.220(c)(3) and 155.221. A QHP issuer DE technology provider, as defined in 45 CFR 155.20, is a business entity that provides technology services or access to an information technology platform to QHP issuers to facilitate participation in DE under 45 CFR 155.221 or 156.1230, including a web-broker that provides services as a DE technology provider to QHP issuers. A QHP issuer DE technology provider that provides technology services or provides access to an information technology platform to a QHP issuer will be a downstream or delegated entity of the QHP issuer that participates or applies to participate as a DE Entity.

DE Entity Website: A CMS-approved QHP issuer or web-broker website that allows new applicants and existing enrollees to enroll in QHPs, either directly with a QHP issuer or through an FFE-registered web-broker, in a manner considered to be through the FFE.

Disconnected Application: When an enrollee (or other third party) creates a new application rather than updating a current one, the new application is referred to as a "disconnected application." This may result in a duplicate enrollment, with the Exchange also auto re-enrolling the consumer based on their original application.

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

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

Enrollment Group (in the individual market FFE): An enrollment group consists of all QIs enrolled and linked by the Exchange-assigned policy identifier. The policy identifier may link additional QIs, such as a custodial parent, but these QIs may not be considered part of the enrollment group.

Enrollment Data Alignment (EDA): The ongoing processes used to ensure consistency of enrollment and financial data between issuers and the FFE. Since CMS makes payment of APTC to QHP issuers based on the enrollment files, all entities' enrollment data must be reconciled. In addition, the enrollment data stored in the FFE is used as the basis for annual generation of Form 1095-A tax data for QIs. 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 FFE but one that the Enrollment Data Reconciliation process identifies) and enters the change directly into their system. By regulation, issuers are required to reconcile enrollment information with the FFE at least monthly.

Form 1095-A: A Form 1095-A is a tax form (like a W-2) that the Exchange furnishes to individuals who are enrolled in QHPs through the Exchange. Form 1095-A provides enrollees with information about their health coverage so they can file their taxes, reconcile APTC, and claim the PTC.

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

Health Reimbursement Arrangement (HRA): An HRA is an account-based group health plan funded solely by employer contributions that reimburses an employee's medical care expenses up to a maximum dollar amount for a coverage period (e.g., a calendar or non-calendar year). Medical care expenses are expenses for medical care as defined under Section 213(d) of the Code. An employer may allow unused amounts to be rolled over for use in subsequent years. In addition to the employee's medical care expenses, an HRA may also reimburse medical care expenses incurred by the employee's spouse, dependents, and children who, as of the end of the taxable year, have not attained age 27 (dependents).

Insurance Affordability Programs: Insurance affordability programs include APTC and CSR, as well as Medicaid, CHIP, and, where applicable, BHP coverage.

Individual Coverage Health Reimbursement Arrangement (ICHRA): An ICHRA is a type of HRA that requires eligible employees and dependents to have individual health insurance coverage or Medicare Parts A (hospital insurance) and B (medical insurance) or Part C (Medicare Advantage). Reimbursements by the ICHRA may include premiums and cost sharing for individual health insurance coverage and for Medicare; employers could begin offering ICHRAs as of January 1, 2020.

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

Marketplace Account: A Marketplace account provides an individual with a username and password to create an individual application and perform other functions related to obtaining health coverage through a Marketplace. A Marketplace account user does not need to be the policyholder for coverage purchased by the Marketplace account user.

Minimum Essential Coverage (MEC): MEC includes a number of different types of coverage outlined in Section 5000A(f) of the Code and in 45 CFR 156.602, such as individual health insurance coverage, job-based coverage, Medicare, certain types of Medicaid, CHIP, TRICARE, and certain other types of coverage. In general, an individual who has MEC (or in the case of employer-sponsored MEC, is eligible for or enrolled in affordable MEC that provides minimum value) is not eligible for APTC or CSR for coverage for themselves.

Modified Adjusted Gross Income (MAGI): MAGI is the figure used to determine eligibility for insurance affordability programs in the Exchanges 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 OEP is the period each year during which a QI may enroll for or change coverage in an individual market QHP through the Exchange (45 CFR 155.20).

Out-of-Pocket Maximum: The out-of-pocket maximum is the maximum amount that an enrollee is required to pay for covered services provided by in-network providers during a given plan year. Once this limit is reached, the plan will cover 100 percent of coverage costs.

Partial Month Premium/Premium Proration: Occurs in the Exchange when an enrollee has periods of coverage that last less than a full month. In the FFE, the prorated monthly premium for partial coverage months is calculated based on the actual number of days that the applicable enrollee(s) has coverage. Specifically, the premium is prorated by dividing the full month premium for one month of the coverage by the number of days in the month and multiplying the resulting quotient by the number of days for which the enrollee had coverage during the partial coverage month.

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

Plan Category Limitations (PCL): As established in the 2017 Market Stabilization Rule, enrollees and their dependents, including newly added household members, who qualify for common SEPs (e.g., due to a loss of health insurance, moving, or a change in household size) are generally only able to enroll in a plan from their current plan category. See 45 CFR 155.420(a)(4).

Product: Product has the meaning set forth in 45 CFR 144.103.

Qualified Health Plan (QHP): A QHP is a health insurance plan that meets certain requirements and, on the basis of meeting those requirements, is certified to be sold through an Exchange. A QHP must be certified by each Exchange through which the QHP is sold. QHP has the meaning set forth in 45 CFR 155.20.

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.

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA): A QSEHRA is a type of HRA created in the 21st Century Cures Act, which permits small employers that do not offer group health plan coverage to help with payment of medical expenses by providing a QSEHRA to their employees. An eligible employee can use a QSEHRA to get reimbursed for medical care expenses, as that term is defined under Section 213(d) of the Internal Revenue Code, for themselves as well as any covered dependents (if permitted by the employer). To receive tax-favored reimbursements from a QSEHRA, an employee and any covered dependents must be enrolled in MEC. Small employers may provide QSEHRAs for plan years beginning on or after January 1, 2017.

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)).

Re-enrollment: A re-enrollment is an 834 enrollment transaction that continues enrollment in coverage through the individual market Exchange. Re-enrollments can be either active, as for an enrollee who returns to the Exchange, generally during the OEP, to make a plan selection for the new plan year, or passive, as when the enrollee does not return to the Exchange to make a plan selection and is automatically re-enrolled in accordance with the hierarchy at 45 CFR 155.335(j).

Rescission: A rescission is a specific type of cancellation or discontinuance of coverage, as set forth in 45 CFR 147.128(b). The cancellation or discontinuance of coverage initiated by the Exchange pursuant to 45 CFR 155.430 (other than paragraph (b)(2)(iii)) is not considered a recission.

System of Exchange Enrollment Data (SEED): SEED is a web application that provides issuers and TPAs with a secure way to access real-time FFE data. SEED supports the FFE EDA and casework processes.

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 (or policyholder) 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 is 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 plan year on behalf of a tax household.

Termination: A termination is an action taken after a coverage effective date that ends an enrollee's enrollment through the Exchange for a date after the original coverage effective date, resulting in a period during which the individual was enrolled in coverage through the Exchange. A cancellation is a specific type of termination.

Web-broker: An individual A/B, group of A/Bs, or business entity registered with an Exchange under 45 CFR 155.220(d)(1) that develops and hosts a non-Exchange website that interfaces with an

Exchange to assist consumers with DE in QHPs offered through the Exchange as described in 45 CFR 155.220(c)(3) or 155.221. The term also includes an A/B DE technology provider.

1.6 Additional Resources

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

Exhibit 2: Additional Resources

Resources	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
Registration for Technical Assistance Portal (REGTAP)	https://regtap.cms.gov
FF-SHOP Hotline	1-800-706-7893 1-888-201-6445 (TTY)
CMSzONE	https://zone.cms.gov
Marketplace Service Desk (MSD)	CMS_FEPS@cms.hhs.gov 1-855-CMS-1515
HICS	hics@cms.hhs.gov 1-888-205-0684
Agent/Broker Help Desk	FFMProducer-AssisterHelpDesk@cms.hhs.gov

For instructions on registering for CMSzONE, visit the CMSzONE End User Guide.

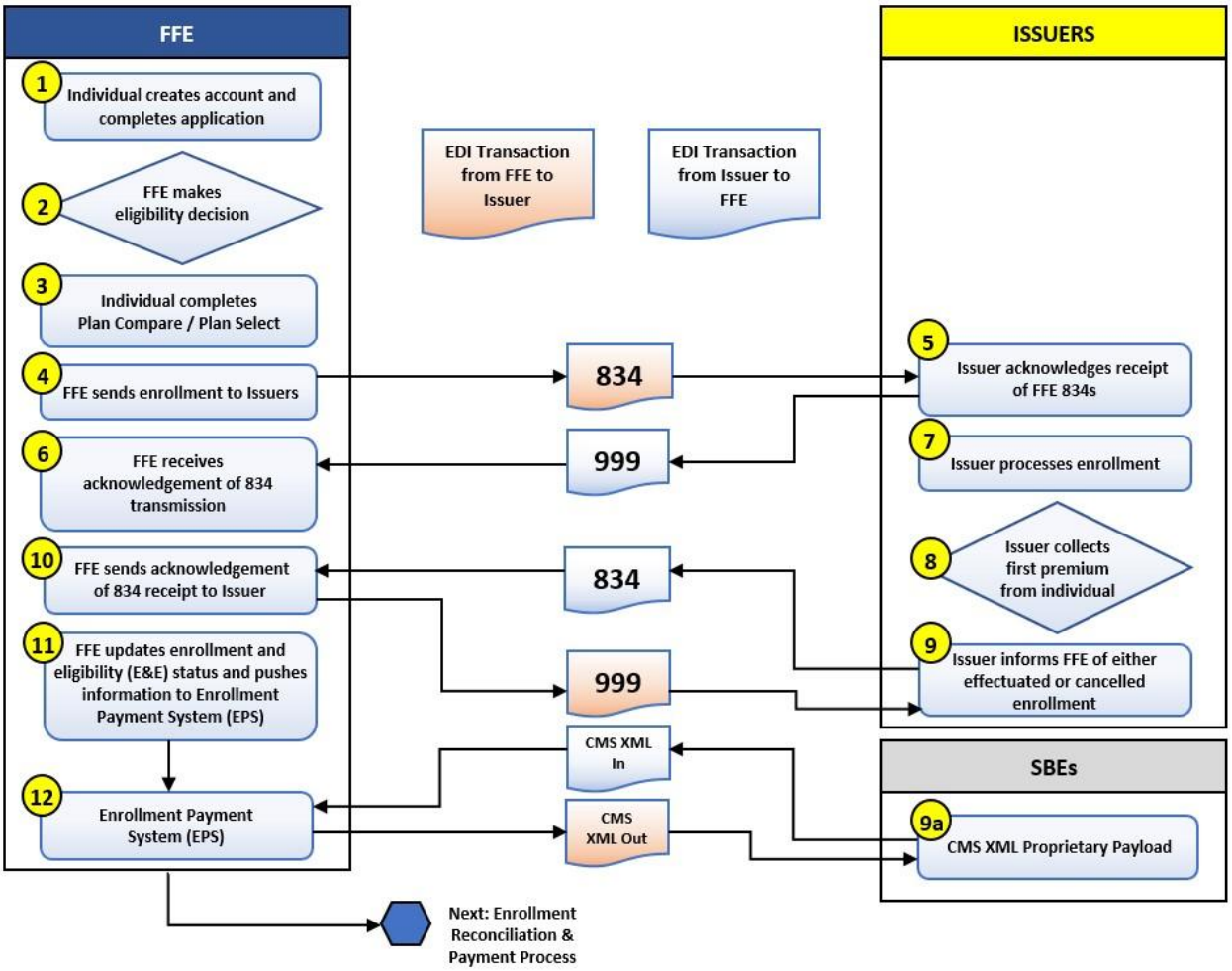
2. Enrollment in the Individual Market FFE (Applicable to QHPs/QDPs)

2.1 Introduction

For qualified individuals (QIs) to purchase coverage in a Qualified Health Plan/Qualified Dental Plan (QHP/QDP) through the Federally-facilitated Exchange (FFE), QIs must enroll in coverage through the FFE during an Open Enrollment Period (OEP) or qualify for a Special Enrollment Period (SEP) (see **Section 5**, **Special Enrollment Periods (Applicable to the Individual Market FFE, QHPs/**). **Exhibit 3** depicts a high-level, end-to-end flow of the process for a QI to enroll in a QHP/QDP through the FFE. Refer to **Exhibit 3** when reviewing the enrollment instructions in the succeeding sections.

NOTE: The following exhibit does not pertain to Direct Enrollment (DE). Refer to **Section 4**, **Direct Enrollment (Applicable to the Individual Market FFE, QHPs/QDPs)**, for the DE process.

Exhibit 3: FFE Enrollment Process



2.2 Eligibility

Pursuant to 45 CFR 155.405, an individual completes a single streamlined application for enrollment in coverage through the Exchange. The Exchange uses this single streamlined application to determine both the QI's eligibility to purchase coverage through the Exchange and, if the applicant chooses to apply for insurance affordability programs, the QI's eligibility for advance payments of the premium tax credit (APTC), cost-sharing reductions (CSRs), and, in some states, Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP).

2.2.1 Requirement to File and Reconcile Past APTC

Internal Revenue Service (IRS) regulations at 26 CFR 1.36B-4(a)(1)(ii) require tax filers to reconcile APTC paid on their behalf for that tax year by filing Form 8962 with their tax return. Each year, as part of the normal OEP processes, Exchanges that use the Federal eligibility and enrollment platform perform a check of IRS data through the Federal Data Services Hub (DSH or the "Hub") to identify whether current consumers who received APTC have filed their Federal income taxes and reconciled APTC. Tax filers who, according to IRS data, have not filed and reconciled APTC as required are referred to as having a Failure to File and Reconcile (FTR) status.

2.2.1.1 Plan Years 2026 and 2027

In the 2024 Notice of Benefit and Payment Parameters,[2] CMS finalized a regulation that required Exchanges to determine QIs ineligible for APTC if they had APTC paid on their behalf for two prior consecutive tax years but they (or their tax filer) did not file a Federal income tax return and reconcile APTC for both of the two prior consecutive tax years (45 CFR 155.305(f)(4)) ("two-tax-year FTR policy").

In the 2025 Marketplace Program Integrity and Affordability Rule, CMS updated the FTR policy for plan year 2026 to require Exchanges to determine a QI ineligible for APTC after one year of failing to file and reconcile ("one-tax-year FTR policy"). The rule sunset at the end of plan year 2026, so that for plan years 2027 and beyond, Exchanges would be required to implement the two-tax-year FTR policy. In *City of Columbus v. Kennedy,* Case No. 1:25-cv-02114 (*City of Columbus II*), the District Court for the District of Maryland vacated "the failure to reconcile policy in the rule's amendment of 45 CFR 155.305(f)(4)."

In the 2027 Notice of Benefit and Payment Parameters, CMS finalized a policy whereby Exchanges could elect to implement either a one-tax-year FTR policy or two-tax-year FTR policy in plan year 2027. The rule stated that the FFE would implement a one-tax-year FTR policy. The rule also required all Exchanges to implement a one-tax-year FTR policy beginning in plan year 2028. Pursuant to an order from the Federal District Court for the District of Maryland in *City of Columbus v. Kennedy*, Case No. 1:26-cv-02215 (*City of Columbus III*), implementation of the FTR policy for 2027 has been stayed while the litigation remains pending. CMS issued guidance directing Exchanges to stop removing or denying APTC for any new applicants or existing enrollees due to having failed to file and reconcile prior years' premium tax credits (PTCs), for plan year 2026 and 2027.[3]

[2] 88 FR 26740
[3] www.cms.gov/files/document/ftr-requirement-py26-27-statement.pdf

2.2.1.2 Plan Year 2028 and Beyond

Neither *City of Columbus II* nor *City of Columbus III* impacted the FTR policy for plan year 2028. Therefore, as finalized in the 2027 Notice of Benefit and Payment Parameters,[4] Exchanges must implement the one-tax-year FTR policy beginning in Fall 2027 for plan year 2028 eligibility determinations. Effective January 1, 2028, enrollees who have failed to file and reconcile for tax year 2026 will no longer be eligible for APTC. CMS will publish additional guidance on FTR operations under the one-year policy in preparation for plan year 2028 in the future.

In January 2028, after the OEP ends, consumers and their tax filer(s) will be subject to further verification of their FTR status if they indicated on their application that they filed and reconciled APTC for the previous year, but this information could not be confirmed by IRS data at the time of application. This post-OEP verification process is referred to as FTR Recheck and is used to identify consumers still in an FTR status. Exchanges on the Federal platform will begin FTR Recheck operations by rechecking IRS data via the Hub to confirm that consumers with an FTR status who previously attested to filing and reconciling on their application during open enrollment have since filed and reconciled their APTC.

Exchanges using the Federal platform will perform a final check of IRS data every year in the spring, using the same FTR Recheck process. If IRS data still indicates that the consumer has an FTR status, the consumer will remain in QHP coverage but will have their APTC ended effective the month after the final check is completed. CMS intends to make this check in April 2028, which means APTC would be removed May 1, 2028.

2.2.2 FTR Notices

Before the OEP begins, Exchanges using the Federal platform will send two types of notices to consumers and their tax filers identified as having an FTR status. “Combined” notices, which do not include Federal tax information, will be sent to consumers identified as having an FTR status, and “direct” notices containing Federal tax information[5] will be sent to the household tax filer. If the consumer and the household tax filer are the same person, the individual will receive both notices.

Direct notices warn the recipient that they are at risk of losing APTC if they do not file and reconcile immediately. The Marketplace Open Enrollment Notice (MOEN) serves as the “combined” for consumers with an FTR status. The MOEN informs them they are at risk of losing their APTC if they fail to complete at least one of several actions listed in the notice immediately, including ensuring that they or their tax filer has filed their Federal income tax return and reconciled APTC.

At the time of FTR Recheck in late January, if IRS data indicates that a consumer has not filed and reconciled as required, the consumer will receive a notice alerting them to take one of the actions listed in the notice in order to remain eligible for APTC. The tax filer will receive an additional educational notice around the same time that alerts them to file their Federal income tax return and reconcile using Form 8962 as soon as possible in order to remain eligible for APTC. If the tax filer’s IRS data still shows that they have an FTR status after approximately sixty days from the time of the FTR Recheck notice has passed, the household’s APTC eligibility will be removed.

[4] Ibid.

[5] Federal tax information is composed of any return or return information received from the IRS or any secondary source that is protected by the confidentiality provisions of IRC Section 6103. This includes the list of individuals generated based on the FTR response code.

During OEP, if the consumer is identified as having an FTR status before OEP begins and does not attest on the new-plan-year application that they or their tax filer have filed and reconciled APTC for the previous plan year, they will be determined ineligible for APTC at the point of application submission and will not receive APTC in the new plan year. If the consumer has an FTR status but attests that they or their tax filer filed and reconciled past APTC, the consumer will be found eligible for APTC at the point of application submission, if otherwise eligible, but will be subject to FTR Recheck after the end of OEP, as described above.

2.2.3 Medicaid and CHIP Eligibility

States that use the Federal Exchange platform, including State-based Exchanges on the Federal Platform (SBE-FPs), have the flexibility to decide whether the FFE or the state will make the final Modified Adjusted Gross Income (MAGI)-based Medicaid and/or CHIP eligibility determination for individuals who apply for coverage with financial assistance at the FFE. In assessment (FFE-A) states, the FFE makes a preliminary assessment of eligibility for MAGI-based Medicaid and/or CHIP, and the state Medicaid/CHIP agency makes a final eligibility determination. In determination (FFE-D) states, the state formally delegates to the FFE the authority to make final eligibility determinations for MAGI-based Medicaid and/or CHIP when the application information is fully verified. In temporary determination (FFE-Temp D) states, the state elects to accept fully verified FFE MAGI-based assessments of eligibility for Medicaid and/or CHIP as final determinations on a temporary basis.[6]

For all states that use the Federal Exchange platform, the FFE screens applicants for potential eligibility for Medicaid based on criteria other than MAGI; the FFE securely and electronically sends account information, known as an account transfer (AT), for individuals who meet applicable non-MAGI criteria to the state agency for a final eligibility determination on a non-MAGI basis.

Also, applicants that the FFE evaluates as ineligible for MAGI-based Medicaid and Emergency Medicaid and who did not attest to a recent Medicaid/CHIP denial by the state can generally request to have their account information sent to the state agency for a full determination. In FFE-A states, the state must evaluate the applicant on all bases (MAGI and non-MAGI). In FFE-D states, the state must evaluate the applicant on a non-MAGI basis only.

Consumers applying for coverage with financial assistance always have the option to apply for Medicaid and CHIP through their state Medicaid/CHIP agency directly. If the state agency determines the applicant ineligible for Medicaid and CHIP, the state will notify the applicant and, in most cases, send their account information securely via AT to the FFE. The FFE will mail the applicant an Inbound AT notice (see sample at https://www.cms.gov/marketplace/in-person-assisters/applications-forms-notices/notices) encouraging the applicant to submit a new or updated FFE application right away to see if they (or other members of their household) are eligible to enroll in an FFE plan and get help with costs.

2.3 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 and may change plans even if the originally selected coverage (active or passive) has been effectuated. However, the last effectuated election made by the end of the OEP will be the coverage in which the

[6] CMS will ask states to identify the timeframe for which they will use FFE-Temp D approach. States that wish to accept FFE eligibility results as determinations indefinitely should formally transition to an FFE-D by formally delegating to the FFE the authority to make MAGI-based eligibility determinations.

QI is enrolled through the FFE.[7] If the QI enrolled in a QHP and paid the first month's premium (i.e., 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 initial QHP in which coverage was effectuated will need to cancel the coverage and refund premiums. The issuer of that initial QHP will receive notification of the plan selection change from the Exchange. Outstanding enrollments will also be identified during Enrollment Data Reconciliation.

For plan year 2027, the coverage effective date for plan selections made during the OEP is the following January 1 (if the plan selection is made between November 1 and December 15) or the following February 1 (if the plan selection is made between December 16 and January 15).[8] However, QIs who qualify for an SEP during the OEP may receive a coverage effective date as indicated in **Section 5**, **Special Enrollment Periods (Applicable to the Individual Market FFE, QHPs/QDPs**). Effective dates for enrollee changes to plan selection post-effectuation align with normal effective dates as established in 45 CFR 155.410(f) (although for some SEPs, accelerated or retroactive effective dates may apply). An enrollee can change plans by contacting the Marketplace Call Center or by logging into their HealthCare.gov account, accessing My Plans and Programs, and selecting ***Change Plan***. Enrollees may change plans during a valid enrollment period without reporting life changes on their applications.

Note that, under 45 CFR 155.310(c), the FFE must accept an application and make an eligibility determination at any point in time during the year. Eligibility determinations made outside the OEP can enable individuals to learn whether they are QIs, whether they are eligible for an SEP for FFE coverage, whether they are eligible for APTC/CSR, or whether they are eligible for Medicaid or CHIP. There are generally no restrictions on when a QI can enroll for Medicaid or CHIP.

Exhibit 4 illustrates OEP plan selection and coverage effective dates for upcoming plan years.

Exhibit 4: Coverage Effective Dates for the FFE OEP

Plan Selection Date	Coverage Effective Date
November 1 – December 15	The following January 1
December 16 – January 15	The following February 1

2.4 Enrollment Transactions

45 CFR 155.270 requires each Exchange to use standards, implementation specifications, operating rules, and code sets adopted by the Department of Health & Human Services (HHS) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Affordable Care Act (ACA) when conducting certain electronic transactions with a covered entity, such as a QHP or QDP issuer. Additionally, HHS oversees and monitors FFE issuers and non-Exchange entities to verify compliance with security and privacy standards, as required by 45 CFR 155.280.

[7] The last plan selection made by December 15 that is effectuated will be the coverage in which the QI is enrolled for a January 1 effective date, while the last plan selection made by January 15 that is effectuated will be the coverage in which the QI is enrolled for a February 1 effective date.

[8] On June 12, 2026, in City of Columbus v. Kennedy, No. 1:25-cv-2114 (D. Md.), the U.S. District Court for the District of Maryland issued an order striking certain provisions of the 2025 Marketplace Integrity and Affordability Final Rule (90 FR 27074). As a result, CMS has not altered the dates for the OEP contained in 45 CFR 155.410(e)(4).

The Exchange, QHP issuers, and QDP issuers 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 an *X12 834 Standard Companion Guide* to be used in conjunction with the *ASC X12 Version 005010 834 TR3*, which outlines transactional information. Additionally, CMS published an *M834 (Maintenance 834) Operations Manual* to explain how certain new data elements, such as APTC and CSR data in the FFE, will be included in the existing version of the 834 enrollment transaction. Issuers offering QHPs or QDPs through the FFE must use the ASC X12 834 enrollment transaction in combination with the updated Companion Guide and Operations Manual for purposes of enrollment transactions. Both documents are available on CMSzONE at https://zone.cms.gov/document/834-enrollment-0.

For purposes of transmitting enrollment information to QHP and QDP issuers, the FFE transmits daily electronic files to the issuers, or their trading partners, in the adopted 834 enrollment transaction. Errors are reported using ASC X12 acknowledgement transactions, including the TA1 and the 999, for syntax and content. This information is explained in greater detail in the Companion Guide.

Retroactive transactions can have either an enrollment or a termination outcome, which could result in impacts to payments, including adjustments to APTC and CSR, as well as other enrollee information, since these transactions are based on plan benefit start and end dates. Retroactive effective dates can result from unforeseen life events, such as death; FFE or issuer error, such as incorrect data being manually entered from a paper application; or an administrative process, such as an eligibility appeal decision. Many of the events and circumstances that result in retroactivity are addressed by regulations on terminations (45 CFR 155.430(d)), SEPs (45 CFR 155.420(b)), redeterminations (45 CFR 155.330(f)), and appeals of eligibility determinations for Exchange participation and insurance affordability programs (45 CFR 155.545(c)). For more information on these topics, refer to **Section 7**, **Terminations (Applicable to the Individual Market FFE, SBE-FPs, QHPs/QDPs)**, **Section 11**, **Eligibility Changes for the Dually Enrolled or Deceased**; **Section 13**, **Implementation of Eligibility Appeal Decisions and Related Enrollments in the FFE**.

The respective sections of the regulations outline the retroactive enrollment or termination effective dates for these triggering events and circumstances. Examples of unique circumstances that may involve retroactive enrollment or termination include:

- If a QI fulfilled all enrollment requirements, but, for some reason, the FFE or QHP/QDP issuer was unable to process the enrollment for the required effective date, the FFE may process a retroactive enrollment effective date.
- If an enrollment was never processed or if a valid termination request was properly made but not processed or acted on by the FFE or the QHP/QDP, the FFE may grant retroactive terminations. These circumstances will be addressed on an individual basis, and the FFE will make determinations of outcomes in collaboration with issuers, when needed.

In most cases, issuers will receive an 834 transaction from the Exchange that communicates the correct retroactive enrollment or termination effective dates; however, in some cases (e.g., an eligible enrollee opts for retroactive effectuation of an appeal decision), CMS notifies the issuers using the Health Insurance Casework System (HICS), which specifies the effective date for the retroactive enrollment or termination and/or application of APTC and CSR amounts.

Unlike a reinstatement, which is a correction of records with the practical effect of "erasing" a prior disenrollment, a retroactive enrollment is an action to enroll a QI into a QHP or QDP for a new period of time. **Exhibit 5** and **Exhibit 6** outline reasons and effective dates for retroactive enrollments and terminations. In some limited cases, CMS may determine that a QI is eligible for an SEP due to an extraordinary circumstance beyond the QI's control and may also permit retroactive enrollment and termination, as necessary.

Exhibit 5: Retroactive Enrollment Reasons and Dates

Reason	Effective Date
Birth, Adoption, Placement for Adoption, or Placement in Foster Care	Date of Event
FFE or QHP/QDP Issuer Error	Date to Be Determined (TBD) by CMS
Exceptional Circumstances	Date TBD by CMS
Eligibility Appeals Outcome	Date TBD by Appeal Outcome

Exhibit 6: Retroactive Termination Reasons and Dates[9]

Reason	Effective Date
Death	Date of Event
Rescission	Policy Start Date
Exhausted Three-Consecutive-Month Grace Period	Last Day of First Month of Grace Period
Exceptional Circumstances	Date TBD by CMS
FFE Termination Error or FFE Systems Limitations	Date TBD by CMS
Eligibility Appeals Outcome	Date TBD by Appeal Outcome

Exhibit 7 provides examples related to retroactivity.

Exhibit 7: 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 FFE sends enrollment information for the enrollment group to the issuer. The issuer receives the transactions and confirms receipt of the transactions by sending an acknowledgement to the FFE. The issuer makes updates to its system. Coverage is effective August 1.

[9] This is not an exhaustive list.

Family Composition	Action	Outcome
Subscriber and Spouse	Subscriber contacts FFE to inform FFE of spouse's sudden death three weeks prior.	The FFE terminates the deceased enrollee's coverage with a prospective termination date and redetermines eligibility for the remaining subscriber. The FFE then assigns a Category 2 HICS case to the issuer specifying a retroactive termination date to be the date of death. The issuer may require additional steps to process the premium refund in accordance with applicable state law, and the FFE recoups any APTC and adjusts issuer user fees.
Subscriber Only	Issuer sends termination transaction to FFE on November 2 with a termination effective date of August 31 for non-payment of premium for a subscriber who is receiving APTC (grace period exhausted October 31).	The issuer sends termination information for the subscriber to the FFE. The issuer makes updates to its system. The issuer 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 three-month grace period.

2.4.1 Initial Enrollment Transaction

Once a QI selects a QHP, and QDP if desired, the FFE sends an 834 enrollment transaction to the issuer. The FFE accumulates transactions and sends the transactions twice daily (at 6:00 a.m. and 6:00 p.m. ET).

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 each generate separate 834 transactions. Issuers must process each transaction in sequence based on the timestamp and Electronic Data Interchange (EDI) file; however, to accurately determine the order of transactions, issuers should pay specific attention to the date and time stamp on the actual 834 enrollment transaction, and not just the date and time on the EDI file.

2.4.2 Confirmation of the 834 Transaction in Individual Market FFE

In the FFE, once the issuer has received the initial 834 enrollment transaction and either full payment or payment within the issuer's established premium payment threshold, in accordance with **Section 6.3**, **Premium Payment Threshold**, for any applicable initial premium due from the enrollee, the issuer must send the FFE a full 834 effectuation/confirmation transaction (Additional Maintenance Reason Code [AMRC] of CONFIRM). The confirmation transaction provides the FFE with verification that the issuer has effectuated the enrollment. Issuers should not wait to confirm enrollment of a QI until after the APTC has been 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 their portion of the binder payment before the coverage effective date, CMS expects QHP and QDP issuers to send the confirmation transaction to the FFE no later than the fifth calendar day of the effective month of coverage. In the case where the binder payment is made after the effective date of coverage and the issuer retroactively effectuates coverage from the date the premium payment is made, CMS expects QHP and QDP issuers to send the confirmation transaction to the FFE without undue delay (up to 48 hours from activation of the policy in the issuer's system). Issuers should be aware that Inbound 834 (IC834) transactions for prior years will not be accepted after the annual cutoff, which typically occurs sometime between late March and late May and is subject to change at CMS discretion.

Additional information on sending 834 effectuation transactions to the individual FFE can be found on CMSzONE at https://zone.cms.gov/document/834-enrollment-0.

2.4.2.1 Examples

Example 2A: A QI selects a QHP on November 20 during the OEP and is therefore assigned a coverage effective date of January 1. 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 is therefore 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. The QHP issuer receives payment of $125 from the QI on December 31. The QHP issuer sends the FFE the 834 confirmation transaction on January 2. The QHP issuer has met the FFE's expectation for timely transmission of the confirmation transaction.

Example 2B: The same circumstances exist from Example 2A. The QI mails a payment of $100 on December 16, and the issuer receives the payment on December 18. The enrollee makes an additional payment towards the initial month's premium of $25 on December 21, and the issuer receives the payment on December 28. The QHP issuer sends the FFE the 834 confirmation transaction on December 30. The QHP issuer has met the FFE's expectation for timely transmission of the confirmation transaction.

2.4.3 Cancellations in the Individual Market FFE

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 (note that the termination transaction may include a termination or end date of the day before, as of 11:59 p.m. ET, the effective date of coverage). QHP and QDP issuers in the FFE may initiate a cancellation transaction if the QI does not pay the binder payment by the deadline the issuer established. Furthermore, if a binder payment made by an enrollee is returned due to insufficient funds, and the deadline for making the binder payment has already passed, the issuer should cancel the enrollee's coverage (if effectuated), unless the FFE or other state authority allows the issuer to implement a reasonable extension of the binder payment deadlines (see **Section 6.1.1**, **Binder and Premium Payment Extensions Directed by the Exchange or State Authority**). CMS expects QHP and QDP issuers to transmit cancellation transactions to the FFE without undue delay (no more than 48 hours after updating the policy to a cancelled status in the issuer's system). However, if the issuer has sent an effectuation to the FFE, and the effective date of the policy has passed, the issuer cannot submit a cancellation under certain circumstances, such as in response to anti-duplication transactions.

NOTE: An exception to this rule is for cancellations of coverage for enrollees who are listed on the Department of the Treasury's Office of Foreign Assets Control (OFAC) sanctions list. Issuers may cancel coverage for such enrollees at any time, without prior approval from CMS, even if coverage has already been effectuated. For additional information about the sanctions list, please visit OFAC's website at https://ofac.treasury.gov/.

A QI may choose to cancel coverage prior to the coverage effective date for any reason (and during a free look period in certain states). For instance, the QI may no longer want or need health insurance coverage through the FFE because they have gained other coverage, or the QI may have changed their mind within an enrollment period about the QHP or QDP they selected and therefore wish to select a different available QHP or QDP.

Cancellation transactions initiated by the QI are voluntary, and the associated request must generally be made on HealthCare.gov, with an Enhanced DE (EDE) partner, or with the Marketplace Call Center. Enrollees may, however, make requests to cancel a Batch Auto Re-enrollment (BAR) policy that is still in passive status directly with an issuer; for more information, see **Section 3.4.9**, **Cancelling BAR Policies in Passive Status (Unwanted BAR)**.

A QI must complete submission of their cancellation request to the FFE by 11:59 p.m. ET on the date prior to the coverage effective date. A QI who enrolled through the FFE cannot request a cancellation after their coverage effective date unless the enrollee is in a free look period or another exception under 45 CFR 155.430(b)(1)(iv)(B) or (C) applies. 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 submits the cancellation request prior to the coverage effective date.

NOTE: If an issuer receives a HICS case to cancel a passive re-enrollment (policy origin 11), the issuer should cancel the auto re-enrollment and does not need CMS approval.

Unless there is a HICS case noting an Enrollment Blocker, the enrollee must cancel or terminate an active policy through the Exchange; however, if an enrollee makes a change to a passive enrollment that results in an M834 transaction (policy origin other than 11), the enrollment is considered an active selection and so must be cancelled through the Exchange.

Issuers may also cancel FFE policies when CMS is satisfied that the issuer has demonstrated that rescission is appropriate and approves the issuer's request to rescind the enrollment, which may include when an enrollment is determined to be an unauthorized enrollment (UE). For additional information on rescissions and UEs, including how to cancel policies approved through these pathways, see **Section 12**, **Addressing Individual and Issuer-Reported Unauthorized Enrollments and Issuer-Reported Fraudulent Enrollments**.

2.4.3.1 Cancellations for Enrollees Residing Outside the Plan's Service Area

Although the Exchange does not, by design, permit enrollees to enroll in a QHP if they do not live in the plan's service area, in some instances issuers may receive an enrollment that is outside of their service area when a consumer in a ZIP Code that spans multiple counties misidentifies their county of residence. When an issuer receives an enrollment for a consumer who does not reside in their service area, the issuer should cancel the policy prior to the effective date using the AMRC of CANCEL-OUT-OF-AREA.

2.4.3.2 Examples

Example 2C: A QI selects a QHP on December 12 during the OEP and therefore is assigned a coverage effective date of January 1. The full monthly premium for the selected plan is $300, and the issuer does not make use of a premium payment threshold. The enrollee qualifies 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, which includes the monthly APTC amount of $125 and the $175 enrollee-responsible portion of the monthly premium. The issuer established a premium payment deadline of 30 days from the coverage effective date.

The enrollee mails the $175 payment on January 30. The issuer does not receive the payment until February 3. The issuer should send the FFE an IC834 cancellation transaction without undue delay and refund the QI $175 because the payment was not received prior to the effective coverage date. Furthermore, the issuer must set the cancellation end date on the IC834 to January 1 as any date after January 1 would indicate a period of active coverage for the policy. Additionally, CMS will recoup any APTC paid to the QHP or QDP issuer and adjust user fees for that enrollee. The issuer should report the cancellation to the FFE during the monthly Enrollment Data Reconciliation process.

Example 2D: The same circumstances exist from Example 2C. The enrollee mails a payment of $100 on December 16, and the issuer has established a premium payment deadline of the effective date of coverage. The issuer receives the payment on December 18. The enrollee makes no further payment towards the initial month's premium. Although the issuer received payment 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) on January 1. The issuer should send the FFE the IC834 cancellation transaction without undue delay and refund the QI $100. Once again, the issuer must set the cancellation end date on the IC834 to January 1, as any later date would indicate a period of active coverage for the policy. Any APTC paid on behalf of the QI must be returned to the FFE.

Example 2E: On December 6, an issuer receives an enrollment transaction for a new enrollee with a start date of January 1. While reviewing the member's information, the issuer notices that while the ZIP Code on the 834 is a valid coverage area for the plan, the county is not. The plan's coverage area does not include the county selected by the enrollee; therefore, the enrollment is not valid. The issuer sends a cancellation transaction to the FFE using the AMRC of CANCEL-OUT-OF-AREA. The issuer also must send a termination notice to the enrollee that includes the reason for the cancellation and cancellation effective date.

2.4.4 Free Look Provisions in the Individual Market FFE (Applicable to QHPs and QDPs)

Certain states have laws that provide a QI in health insurance coverage a free look period. These provisions allow an enrollee to retroactively cancel coverage in a QHP or QDP in the FFE, within a certain period of time after their coverage effective date. In states with laws providing for a free look period, an enrollee in the FFE may request cancellation of coverage in their QHP and QDP after first terminating their coverage through the FFE. Because rules can vary by state, QHP and QDP issuers may initiate free look cancellations as long as the requests from enrollees are consistent with applicable state laws. Issuers are encouraged to use the AMRC for free look cancellations pursuant to the ASC X12 834 Standard Companion Guide described earlier in this section.

The premium refund policy in the case of free look cancellations follows 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 APTC paid to the QHP or QDP issuer and adjust user fees for that enrollee. The issuer should report the cancellation to the FFE during the monthly Enrollment Data Reconciliation process. CMS will not initiate an enrollment cancellation through an 834 or through HICS as the result of a QI seeking a cancellation under free look provisions.

If a QI cancels their QHP or QDP coverage during the OEP, the QI may select a new QHP or QDP. Cancellation under a free look period does not qualify the enrollee for an SEP for loss of minimum essential coverage (MEC).

2.4.4.1 Examples

Example 2F: In the FFE, a QI residing in a state with a free look period selects a QHP on December 5 with a coverage effective date of January 1. The enrollee takes the necessary actions that would qualify them for a free look cancellation within 30 days 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. The QI may return to the FFE to select new coverage if they qualify for an SEP. The QI is not eligible for an SEP as a result of the cancellation of their Exchange coverage.

Example 2G: In the FFE, a QI who is eligible for an SEP and who is residing in a state with a free look period selects a QHP on January 5 with a coverage effective date of February 1. The enrollee takes the necessary actions that would qualify them for a free look cancellation within 30 days 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. The QI is not eligible for another SEP because of the cancellation of their Exchange coverage. To enroll in coverage through the FFE, the QI must wait until the next OEP or must qualify for an SEP, as provided for in 45 CFR 155.420.

2.5 Application and Enrollment Changes

In accordance with 45 CFR 155.330(b) and as specified in 45 CFR 155.305, enrollees and tax filers are required to report changes to information on their applications no later than 30 days after the changes happen. These changes can be reported to the FFE online or by calling the Marketplace Call Center. Some updates reported by the enrollee may result in changes to an enrollee's eligibility for coverage or financial assistance through the FFE or may qualify the enrollee for an SEP. If changes are not reported, the tax filer may be liable for repaying some or all APTC received during the year.

Issuers should instruct enrollees to follow the process for reporting changes through the FFE outlined in **Exhibit 8**.

Exhibit 8: Process for Reporting Changes via HealthCare.gov

Step	Process
1	The QI logs in to their account, selects their current-year application, and selects the ***Report a Life Change*** button. This button is enabled only for QIs who have a current-year application.

Step	Process
2	The QI lands on a page with information about the types of changes that must be reported to the Exchange. The next screen allows the QI to change household eligibility information, make changes to notification preferences, or report a move to a new state.
3	If the QI reports changes that may affect eligibility, an updated copy of their application is created, pre-populating some information and attestations from their earlier application.
4	The QI updates the application and answers questions that determine whether the (new) applicants or (existing) QI are eligible for QHP and/or QDP enrollment through the FFE (and financial assistance if requested), and if so, whether the new information triggers an SEP.
5	If a QI is eligible for an SEP, the QI's Eligibility Determination Notice (EDN) contains SEP eligibility language.
6	If any applicant for whom new information is being provided is eligible to enroll in a QHP and/or QDP through an Exchange (i.e., they are QIs), the QI proceeds to the enrollment to-do list page to finish QHP and/or QDP enrollment(s) for all QIs on the application.
6a	If new information is being provided for an applicant based on an event that triggers an SEP, all QIs on the application can compare and select from QHPs and QDPs available in their service area under the plan category restrictions for the corresponding SEP.
6b	If the new information provided does not trigger an SEP, the QI is limited to selecting the QHP/QDP in which they are currently enrolled. This non-SEP selection will provide the QHP/QDP with the updated enrollment information.
7	If applicable, the QI eligible for an SEP sets the amount of APTC the tax household will use and selects a new plan or the existing plan (depending on the situation).
8	Once the QI eligible for an SEP selects a plan, the system generates enrollment transactions to the issuer, as appropriate, based on the plan selected. • Updates that maintain the same subscriber and the same FFE policy ID are sent as M834 transactions. • Updates that change the subscriber or QHP/QDP ID also change the FFE policy ID and thus are sent as Change in Circumstance (CIC) transactions.

In some limited cases, in addition to reporting the change on an application, the enrollee may need to submit a new application to enroll in coverage. The enrollee must create a new application when the enrollee has moved to a new state or when the enrollee will no longer be on the same Federal income tax return as the other enrollees on the current application (e.g., due to a divorce or when a young adult will no longer be claimed as a tax dependent by their parents). When this occurs outside the OEP, the enrollee could qualify for an SEP based on the loss of their previous FFE coverage or due to gaining access to new QHPs because of a permanent move. In general, QIs do not need to create a new application in order to report a change.

The (non-exhaustive) list of reportable changes is as follows:

- Change in projected annual household income for the plan year or change to current month's household income

- Addition or removal of other applicants or non-applicant household members listed on application (e.g., when there is a birth, death, or marriage)
- Relocation/change of address to a new ZIP Code or county
- Gain or loss of other health coverage
- Pregnancy (may affect Medicaid eligibility under applicable state rules)
- Change in full-time student status for 18-22-year-olds (could affect Medicaid eligibility under applicable state rules)
- Becoming the primary caretaker for a child living with you (could affect Medicaid eligibility under applicable state rules)
- Change in tax filing status (e.g., will or will not file, joint or separate filer) or change in tax dependents who will be claimed
- Newly incarcerated or released from incarceration
- Change in immigration status or citizenship
- Change in status as member of Federally recognized tribe
- Change in disability status or need for long-term care (could affect Medicaid eligibility under applicable state rules)
- Change to available employer coverage
- Change in enrollment in other health coverage
- Change, including corrections and updates, to the relationships between family members

Enrollees can also report changes during annual eligibility redetermination. For more information on the redetermination process, see **Section 3**, **Redeterminations and Renewals in the Individual Market FFE (Annual Open Enrollment)**.

NOTE: For information on whether reported changes are classified as financial or demographic, refer to Section 2.2 of the *M834 Operations Manual*, which can be found on CMSzONE at https://zone.cms.gov/document/834-enrollment-0.

2.5.1 Age Rating and Accumulators

In accordance with 45 CFR 147.102(a)(1)(iii), QHP issuers must use an enrollee's age as of the date of policy issuance or renewal to conduct age rating. Issuers are not permitted to re-rate an enrollee based on age during the plan year if the enrollee remains on the original policy. New enrollees who enroll during the middle of the plan year will be age-rated by the FFE as of the date they enroll in coverage. If a dependent is added in the middle of the plan year, the FFE age rates the dependent as of the date of their enrollment, while the subscriber retains the age rating they received when the coverage began. If an existing subscriber selects a new plan in the middle of the plan year (involving a change in the 14-character plan ID), then the FFE age rates all enrollees on the policy as of the start date of their new policy. Finally, if the original subscriber on a policy is removed during the plan year, the FFE assigns a new subscriber to the policy from the remaining enrollees and age-rates all remaining QIs as of the new policy start date.

If the FFE does not assign the rates as described here, an issuer may generally use Enrollment Data Alignment (EDA) to make corrections. If the FFE re-rates an enrollee after a CIC due to a new FFE policy ID being assigned but the issuer is required by state law or business rule to continue the original premium, the issuer may use EDA to change the FFE policy premium so that the age rating is based on

the original start date. Issuers must use the annual renewal date of January 1 to age rate enrollees when coverage continues into the next plan year.

The same principle applies to accumulators, such as deductibles and maximum out-of-pocket limits. Accumulators may not be reset for an enrollee or group of enrollees remaining in the same policy, as indicated by the FFE policy ID remaining unchanged after the CIC. Accumulators may be reset at the beginning of the plan year or when a new policy is issued (typically indicated by the FFE assigning a new FFE policy ID), as occurs when a new plan is selected or a new subscriber is identified. Issuers should also refer to the laws in their state, which may be more consumer protective regarding when accumulators may be reset. Changes in eligibility for CSRs, known as CSR variants and indicated on the 834 by the two-digit suffix to the plan ID, are not new policy issuances; thus, accumulators must not be reset, consistent with 45 CFR 156.425(b).

2.5.1.1 Child Rating Limitations

In accordance with 45 CFR 147.102(c)(1), the FFE takes into account no more than the three oldest covered children when calculating the total premium. Multiple enrollment scenarios involving QIs under the age of 21 can exist, and the determination of who is included or excluded in the calculation of total family premiums is based on the following:

- When a subscriber is age 21 or older, only the three oldest dependents (any relation other than spouse) aged 20 or younger are included as the three oldest covered children.
- When a subscriber is age 20 or younger and the subscriber is neither the parent nor the spouse of any of the included dependents, the subscriber is considered to be one of the three oldest covered children.
- When a subscriber is age 20 or younger and the policy includes an individual aged 20 or younger who is the spouse of the subscriber, neither the subscriber nor the spouse are considered to be covered children.
- When a subscriber is age 20 or younger and the subscriber is the parent of any included dependent aged 20 or younger, the subscriber is not considered to be one of the three oldest covered children.

2.6 Electronic Notice Requirements

Issuers have asked CMS whether it is permissible to send notices to enrollees electronically rather than through standard mail. In general, CMS regulations do not prohibit issuers from providing notices electronically. When sending notices electronically, issuers should ensure that the following conditions are met:

- The enrollee has been given a choice of either standard mail or electronic communication.
- The enrollee has consented to electronic communication.
- The issuer satisfies the requirements for electronic notices under other applicable Federal or state law.

If an issuer cannot send all other supporting materials electronically along with the notice, the issuer must provide the notice through standard mail. Issuers are encouraged to contact their state's Department of Insurance to ensure that any electronic communications comply with state regulations.

3. REDETERMINATIONS AND RENEWALS IN THE INDIVIDUAL MARKET FFE (ANNUAL OPEN ENROLLMENT)

3.1 Introduction

Pursuant to 45 CFR 155.335, an Exchange has 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 Exchange that such procedures meet specified criteria. The alternative procedures utilized by the Federally-facilitated Exchange (FFE) are published as written guidance on redetermination and re-enrollment on the Center for Consumer Information & Insurance Oversight (CCIIO) website.[10]

In advance of the Open Enrollment Period (OEP) for each plan year, the FFE will provide a Marketplace Open Enrollment Notice (MOEN) to all qualified individuals (QIs) currently enrolled in Qualified Health Plans/Qualified Dental Plans (QHPs/QDPs) through the FFE for the upcoming plan year. This notice focuses on announcing the OEP and contains other 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 plan selections may be made for coverage starting on January 1 or February 1 of the upcoming plan year. Information specific to the enrollment, such as the upcoming plan year premium and any financial assistance (possibly initially estimated), comes from the issuer's renewal or discontinuation notice, supplementary notice, and/or January or February invoice.

MOENs contain special messaging for QIs who are at risk of having their advance payments of the premium tax credit (APTC) discontinued in the new plan year. These groups include, but are not limited to:

- Opt-Out Group: QIs enrolled in QHPs with APTC or income-based cost-sharing reduction (CSR) for the current plan year who did not authorize the FFE to request updated tax return information for the purpose of annual redetermination or have an expired authorization
- Failure to File and Reconcile (FTR): QIs enrolled in QHPs with APTC for the current plan year and/or whose tax filer(s) did not comply with the tax filing and APTC reconciliation requirement for that year under 45 CFR 155.305(f)(4).[11]
- Repeat Passive Re-enrollees: QIs who were automatically re-enrolled with APTC or income-based CSR for the past two consecutive plan years and have no tax data (meaning, no income or FTR indicator) available from the Internal Revenue Service (IRS) for the previous two relevant tax years
- Special Notice Group (SNG): QIs whose IRS data reflects household income in excess of 500% Federal Poverty Level (FPL).

[10] For the 2024 and later plan years, the annual redetermination/re-enrollment guidance was published on August 14, 2023, at https://www.cms.gov/files/document/guidance-annual-redetermination-and-re-enrollment-marketplace-coverage-2024-and-later-years.pdf.

[11] MOENs will not contain messaging about FTR for plan year 2027. Please see additional information in **Section 2.2.1**, **Requirement to File and Reconcile Past APTC**.

Notices for these groups contain the same information as the standard notice, along with an explanation that the FFE strongly encourages enrollees receiving APTC or CSR to contact the FFE to obtain an updated eligibility determination 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). Enrollees who fall in the FTR group will also be reminded that they must file a tax return to continue to qualify for financial help.[12]

> ***For examples of MOENs, see Marketplace Open Enrollment and Annual Redetermination Notices*** *at* https://www.cms.gov/marketplace/in-person-assisters/applications-forms-notices/notices.

For a QI at risk of losing financial assistance for one of the reasons described above, and who does not contact the FFE to obtain an updated eligibility determination and select a QHP by December 15, the FFE will establish future year eligibility based on a hierarchy of the most recent income data available and re-enroll the QI in QHP coverage without APTC or CSR. The FFE may use either IRS data, if available, or verified, QI-provided application data, which is verified either through external data sources (EDSs) or a manual documentation submission process, whichever is most recent. The FFE uses this income data, together with updated FPL tables and benchmark plan premium information, to update eligibility for APTC and CSR.

For information on the FTR process for consumers, see **Section 2.2**, **Eligibility**.

3.2 Re-enrollment

Re-enrollment 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) or with a different issuer. Re-enrollment for the next plan year can be either active or passive.

3.2.1 Active Re-enrollment

An active re-enrollment is initiated by an enrollee returning to the FFE during the OEP to submit an application and select a plan for the next plan year. It is important that current FFE enrollees who are seeking to actively re-enroll work from future-year applications that are tied to their current-year applications, rather than creating brand new applications (e.g., through a new HealthCare.gov account) that are not pre-populated from their current-year application. This approach provides enrollees with the benefit of pre-populated applications and helps the FFE and issuers maintain continuity in enrollments. Tips for enrollees who are having 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/.

Note that it is very important for enrollees or their agents or brokers (A/Bs) to access their respective existing Exchange accounts so that they can receive a pre-populated eligibility application for the future plan year. This allows the Exchange to accurately connect the future-year enrollment with the current-year enrollment. Failure to use a pre-populated application to enroll in future-year coverage may lead to duplicate enrollments and QI confusion.

[12] MOENs will not contain messaging about FTR for plan year 2027. Please see additional information in **Section 2.2.1**, **Requirement to File and Reconcile Past APTC**.

Prior to assisting a QI, the A/B should determine if the QI has an existing application. Failure to follow these steps can create confusion for the enrollee as well as the issuer, as duplicate enrollments may be created if an existing enrollee's pre-populated future-year application is not accessed. To prevent unnecessary creation of a new application, the A/B application search returns applications for both the current and future year when the A/B searches for the current-year application, prevents an A/B from pre-populating another future-year application using a current-year application when a future-year application already exists, and only displays an application with an active policy for a given year, when one is available.

3.2.2 Passive Re-enrollment/BAR

Passive re-enrollment, also called Batch Auto Re-enrollment (BAR), is the process that the FFE uses to re-enroll current enrollees who do not return to the FFE to submit an application and select a plan by December 15. This helps ensure that the current enrollees have coverage on January 1 of the following year.

CMS uses a crosswalk (found at 45 CFR 155.335(j)(1) through (4)) to determine an appropriate plan for the upcoming year, which is created through a combination of issuer submissions, and in certain cases state direction. Issuers submit the Plan ID Crosswalk Template with other plan materials during the QHP certification process. The FFE uses the Plan ID Crosswalk Template to conduct passive re-enrollments.

Auto re-enrollment runs as follows:

- **October Wave**: This wave starts around mid-October and includes all enrollees eligible for renewal who are being re-enrolled into a plan offered by the same issuer or matched to an alternate plan from a different issuer by CMS or a state insurance department, as applicable. CMS's goal is to complete this wave by November 1.
- **Incremental Wave**: This wave starts around late November/early December and includes new current-year enrollees who enrolled after the October BAR wave and enrollees whose auto re-enrollment is being updated because the enrollee or Exchange reported new eligibility information for the current year after the October BAR wave.
- **December Wave**: This wave starts around mid-December and includes new current-year enrollees who enrolled after the November BAR wave and enrollees whose auto re-enrollment is being updated because the enrollee or Exchange reported new eligibility information for the current year after the November BAR wave.

CMS's goal is for issuers to receive most passive re-enrollment transactions before the start of the OEP, allowing time for the issuers to process and track renewals and prepare issuer-provided re-enrollment notices that identify the re-enrollment plan and financial information if the QI is auto re-enrolled. Enrollees who visit HealthCare.gov and check their Marketplace accounts during the OEP will not see their passive re-enrollment until December 16; however, when the enrollee is determined eligible to enroll in a QHP through the Exchange and proceeds to plan selection, the enrollee will see the re-enrollment plan pre-selected for their convenience.

Issuers may communicate with QIs regarding these re-enrollment transactions but should not send an invoice for future-year coverage until after the OEP starts. An enrollee has until December 31 to indicate to the Exchange that they do not want to be auto re-enrolled by opting out of passive re-enrollment through BAR on HealthCare.gov or an Enhanced Direct Enrollment (EDE) platform.

Confirming "Stop Coverage for [Future Year]" will send a current-year policy termination that day, effective December 31, and simultaneously cancel the future-year BAR policy (if already sent) or block BAR from running for that application (if BAR has not already been executed for that application).

For passive re-enrollments, issuers must re-enroll each enrollee in a QHP in accordance with the BAR re-enrollment transactions sent, which follow the hierarchy described in 45 CFR 155.335(j). Starting in plan year 2024, per 45 CFR 155.335(j)(1) and (2) as amended by the Notice of Benefit and Payment Parameters for 2024, this generally requires that an enrollee be renewed in the same QHP if available or a plan in the same product that has the most similar network compared with the enrollee's current QHP if available through the Exchange. If no plan in the same product is available through the Exchange, the issuer may re-enroll the enrollee into a different product available through the Exchange that is the most similar to the enrollee's current product and that has the most similar network compared with the enrollee's current QHP. If an enrollee's current Silver-level QHP is not available and the enrollee's current product no longer includes a Silver-level QHP that is available to the enrollee through the Exchange, the enrollee should be re-enrolled in a Silver-level QHP in the product offered by the same issuer that is the most similar to the enrollee's current product rather than in a plan one metal level higher or lower than their current Silver-level QHP but within the same product.

If an enrollee has not yet been passively re-enrolled and makes an active plan selection for the upcoming year, the enrollee will not be passively re-enrolled through BAR. Additionally, active plan selections through December 15 automatically cancel or update any auto re-enrollment already sent for the enrollee. If an enrollee updates their current-year coverage after they were passively re-enrolled for the next plan year, those changes generally will be carried forward to the next plan year's policy through the December BAR process. However, if an enrollee makes an active update to their next plan year's policy, subsequent updates to current-year coverage will not be automatically carried forward to the next plan year's policy through the December BAR process. Absent a Special Enrollment Period (SEP), such as Loss of Minimum Essential Coverage (MEC) due to the current-year issuer discontinuing coverage, a QI must make an active plan selection by December 15 for an effective date of January 1. Plan selections made between December 16 to January 15 have an effective date of February 1. If the enrollee makes an active plan selection before December 15, issuers should disregard any passive re-enrollment transaction previously sent by the FFE, even if received out of sequence. A QI can make an election at any time during the OEP or during an SEP, even if a previous passive or active re-enrollment has been effectuated. The new coverage starts in accordance with normal effective dates.

3.2.3 BAR Operational Process

The FFE completes the following:

1. Select the application with a current, active enrollment.
2. Pre-populate a future-year application.
   NOTE: This application is not visible to the enrollee until the enrollee logs into their Marketplace account on or after the first day of the OEP.
3. Create a future-year enrollment using the Plan ID Crosswalk Template provided by the issuer or in an alternate plan from a different issuer (see **Section 3.2.4**, **Alternate Enrollments**).
   NOTE: This enrollment will be visible to the QI on December 16 if the QI does not actively select a plan for the upcoming plan year.

4. Send the enrollment transaction to the issuer.
5. Repeat steps 1–4 for the incremental and December waves.
6. Generate an Eligibility Determination Notice (EDN) and Enrollment Confirmation Message for enrollees who did not make an active plan selection by the last day to make a plan selection for coverage effective on January 1.

3.2.4 Alternate Enrollments

Where no QHP from the same issuer is available to enrollees through the Exchange, then to the extent permitted by applicable state law, an enrollee may be auto re-enrolled in a plan with a different issuer. This process does not apply to QDPs. In such cases, re-enrollments are conducted as directed by the applicable state regulatory authority. If the applicable state's regulatory authority declines to act, to the extent permitted by applicable state law, the Exchange will re-enroll the affected enrollee in a similar QHP from a different issuer within a service area that covers the enrollee's location, taking into account the issuer's ability to absorb the new enrollment and the lowest premium plan.

- The FFE performs this auto re-enrollment process according to the following hierarchy pursuant to 45 CFR 155.335(j)(3), which prioritizes finding a policy offered by a different issuer that is similar to the enrollee's current coverage. The enrollee will be auto re-enrolled in a QHP at the same coverage level under the same product network type in the same service area.
- If no QHP is available at the same coverage level under the same product network type in the same service area, the enrollee will be auto re-enrolled in a QHP at the same coverage level under a different but similar (if possible) product network type.
- If no QHP is available from the same coverage level under a different product network type in the same service area, the enrollee will be auto re-enrolled in a QHP that is one coverage level lower than the enrollee's current QHP under the same product network type.
- If no QHP is available that is one coverage level lower than the enrollee's current QHP under the same product network type in the same service area, the enrollee will be auto re-enrolled in a QHP that is one coverage level lower than the enrollee's current QHP under a different but similar (if possible) product network type.
- If no QHP is available that is one coverage level lower than the enrollee's current QHP under a different product network type in the same service area, the enrollee will be auto re-enrolled in a QHP that is one coverage level higher than the enrollee's current QHP under the same product network type.
- If no QHP is available that is one coverage level higher than the enrollee's current QHP under the same product network type in the same service area, the enrollee will be auto re-enrolled in a QHP that is one coverage level higher than the enrollee's current QHP under a different but similar (if possible) product network type.
- If no QHP is available that is one coverage level higher than the enrollee's current QHP under a different product network type in the same service area, the enrollee will be auto re-enrolled in a QHP at any coverage level under the same product network type.
- If no QHP is available for enrollment at any coverage level under the same product network type in the same service area, the enrollee will be auto re-enrolled in a QHP at any coverage level under a different but similar (if possible) product network type.

- If the enrollee's current QHP is a catastrophic plan as described in Section 1302(e) of the Affordable Care Act (ACA) and the enrollee will no longer meet the criteria for enrollment in a catastrophic plan as described in Section 1302(e)(2) of the ACA, the enrollee will be auto re-enrolled in a Bronze level QHP under the same product network type in the same service area. If no Bronze plan is available under the same product type in the same service area, the enrollee will be auto re-enrolled in the QHP with the lowest coverage level offered under the product type.
- An enrollee whose current QHP is at a metal level as described under Section 1302(d) of the ACA will not be auto re-enrolled into catastrophic coverage as described under Section 1302(e).

The Exchange sends this type of auto re-enrollment to the future year issuer with an Electronic File Transfer (EFT) code of I834 and Additional Maintenance Reason Code (AMRC) of PASSIVE – NEW TO ISSUER, in contrast to other passive re-enrollments, which are sent with an EFT code of I834AR, and can have several different AMRCs, summarized in **Exhibit 9**. For a smoother enrollment experience, CMS encourages enrollees who wish to change plans to select a plan by December 15, to have an effective date of January 1, though these enrollees are generally eligible for an accelerated SEP that permits plan changes for January 1 coverage until December 31.

3.2.5 Re-enrollment Communications to Enrollees

3.2.5.1 Notices from the FFE to Returning Enrollees

In addition to the MOEN, enrollees who are re-enrolled in coverage through a new issuer consistent with 45 CFR 155.335(j)(3) will also receive a Cross Issuer Notice (CIN)[13] from the FFE. The new issuer may start messaging to consumers before open enrollment to communicate the alternate enrollment process, but CMS recommends that the new issuer not bill before open enrollment, if possible, to encourage consumers to review options and actively select a plan for January. If the enrollee pays the binder payment or otherwise effectuates coverage with the new issuer, the new issuer must send the enrollment information package ("welcome package") described in 45 CFR 156.265(e).

If the enrollee has not returned to the Exchange to make an active selection for the next plan year by December 15, for an effective date of January 1, the Exchange will send both an updated EDN and an Enrollment Confirmation Message to the enrollee. These notices inform the enrollee of their eligibility determination for the upcoming plan year and of their passive re-enrollment status. The Enrollment Confirmation Message notes whether the enrollee(s) on the relevant application was successfully re-enrolled. If the enrollee(s) was re-enrolled, the confirmation message provides the plan name(s), plan ID(s), and information about any financial assistance that was applied.

If BAR fails (see **Section 3.2.6**, **BAR Failure Report to Issuers**), the Exchange does not generate an EDN because the EDN is dependent on all QIs on the application enrolling in coverage. Enrollees who cannot be re-enrolled due to BAR failure will receive an Enrollment Confirmation message informing them that they do not have a plan for the future plan year, and that they are eligible for a 60-day SEP.

[13] See "Cross-Issuer Notices" at https://www.cms.gov/marketplace/in-person-assisters/applications-forms-notices/notices.

3.2.5.2 Notices from Issuers to Returning Enrollees

Issuers are also required to send notices of product renewal and discontinuation to current enrollees as specified in 45 CFR 147.106 and 156.1255. An issuer must provide written notice of renewal [14] before the first day of the next OEP. For grandfathered coverage on the Exchange, an issuer must provide to each individual written notice of renewal at least 60 calendar days before the date of the renewal of the coverage.

For more information on Federal standard notices of product discontinuation and renewal in connection with the OEP, issuers can review the latest CMS guidance under the Health Insurance Market Reforms heading and the Guidance subheading at Regulations and Guidance | CMS. Issuers should note that, as indicated in the instructions to the Federal standard notices, if the FFE is not yet able to determine APTC eligibility for a future year, the issuer may use current-year APTC as an express estimate and communicate to the consumer that APTC will change for the upcoming year. Consistent with the Federal standard notices, issuers using current-year APTC as the estimated future-year APTC should explicitly note that in their communications. When the issuer receives updated eligibility information from the FFE that changes the amount of APTC an enrollee is receiving, the issuer should provide an additional notice or reflect the APTC change on the January premium billing notice and provide a new Summary of Benefits and Coverage consistent with 45 CFR 156.425(c) if the CSR variant has changed.

To account for situations when individuals enroll in a product that will be discontinued (e.g., during an SEP) after the specified deadline for providing the product discontinuation notice and before the product is discontinued, CMS will consider an issuer as having satisfied the requirement to provide notice of product discontinuation if (1) the issuer provides notice of the discontinuation in accordance with the regulatory requirements to each individual who is enrolled in coverage under the product being discontinued at the time that notice must be provided; and (2) in the case of individuals who enroll in the product after the original discontinuation notice deadline, the issuer provides notice to such individuals at the time of application or enrollment that the product will be discontinued, in any form and manner permitted by applicable law and regulations.[15]

3.2.6 BAR Failure Report to Issuers

There are some BAR transactions that cannot be processed due to technical issues, though this represents a very small portion of all applications. CMS sends the BAR Failure report to issuers who had BAR transactions that were unsuccessful due to technical issues; therefore, not all issuers receive the report. CMS generally sends the BAR Failure report to impacted issuers in late December or early January of the plan year using the EFT IOUTRC function code.

This report contains enrollee contact information. Issuers are encouraged to use this file for voluntary outreach to enrollees; the goal is for the enrollees to actively re-enroll through the FFE. Enrollees on the BAR Failure report are eligible for a 60-day SEP. The Marketplace Call Center flags these enrollments for an optional January 1 effective date if the enrollee actively returns to the FFE and makes a plan selection by March 1. The Exchange also conducts outreach to these enrollees. When these enrollees contact the Marketplace Call Center, they may enroll in coverage with either a

[14] For notice requirements on current-year enrollments received after the OEP begins, refer to this guidance published on September 2, 2014, at https:/www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Renewal-Notices-9-3-14-FINAL.PDF.
[15] Ibid.

prospective effective date or a retroactive effective date of January 1. In both of these scenarios, the 834 will have a prospective date. If the consumer elects a retroactive effective date of January 1, the Marketplace Call Center will open a Health Insurance Casework System (HICS) case.

3.3 Enrollment Transaction Types

Because the FFE auto re-enrolls the vast majority of members before the OEP begins, most active re-enrollments are sent as Maintenance 834 (M834) transactions. CMS sends active re-enrollments for the future plan year's coverage to issuers in daily batches as 834 initial enrollments, in accordance with FFE procedures. Active re-enrollment 834 transactions sent to issuers also include plan selection changes made for the new plan year, such as when an enrollee replaces future-year plan A with future-year plan B during the OEP. Plan selection changes are sent as cancellation/termination transactions to the first issuer and initial enrollment transactions to the gaining issuer. Plan selection changes are not sent as M834 transactions. CMS sends regular Change in Circumstance (CIC) transactions to issuers when enrollees report a change to their application information (e.g., updated income, new phone number, or new family member) for either the current or next year's coverage.[16]

The FFE sends passive re-enrollment transactions as part of the BAR process described in **Section 3.2.2**, **Passive Re-enrollment/BAR**. There are two populations for which an issuer may receive updates after the initial auto re-enrollment. These updates are sent to issuers via M834 transactions in the December BAR wave. The first population consists of enrollees reporting a current-year CIC after having been auto re-enrolled for the future year. For these cases, the associated M834 transaction updates the future-year plan to include the eligibility update made due to the current-year CIC. The second population, which is referred to as the submitted-not-enrolled (SNE) population, is made up of re-enrollees who submitted an active future-year application but did not complete an active future-year plan selection. For these cases, the associated M834 transaction updates the future-year enrollment with the eligibility information reported in the active future-year enrollment.

CMS sends passive re-enrollments, with the exception of alternate enrollments with new issuers, as initial enrollment transactions with a Maintenance Type Code (MTC) (INS03) of 021 (Addition), an MRC (INS04) of 41, and an AMRC that identifies that the auto re-enrollment is in either effectuated or initial status. All passive re-enrollments have an effective date of January 1, and most are sent with the EFT function code I834AR; however, alternate enrollments are sent with the EFT function code I834. **Exhibit 9** provides a non-exhaustive list of passive re-enrollment groupings and their corresponding maintenance codes, Origin Type, binder requirement, and function code.

Exhibit 9: Passive Re-enrollment Codes

Grouping	MTC	MRC Sent/ Received	Origin Type	AMRC	Binder Required/ Issuer Confirms Effectuation	EFT Function Code
BAR Effectuated	021	41/NA	11	PASSIVE	N	I834AR
BAR Initial	021	41/28	11	PASSIVE - INITIAL	N	I834AR

[16] For specific transactional information about CICs performed on current-year policies, refer to Section 2.2 of the *M834 Operations Manual* on CMSzONE at https://zone.cms.gov/document/834-enrollment-0.

Grouping	MTC	MRC Sent/ Received	Origin Type	AMRC	Binder Required/ Issuer Confirms Effectuation	EFT Function Code
BAR New Subscriber (e.g., a young adult who will have aged out as a dependent by the year's end and is being re-enrolled as a subscriber)	021	41/28	11	PASSIVE - NEW SUBSCRIBER	Y	I834AR
BAR New Issuer (i.e., an enrollee who is auto re-enrolled by CMS because no plans are available to the enrollee from the current-year issuer)	021	EC/28	11	PASSIVE REENROLL - NEW TO ISSUER	Y	I834AR

Issuers should not continue an enrollment through the Exchange into the future plan year unless the issuer receives an 834 enrollment transaction from the FFE or finds the enrollment listed on a future-year Pre-Audit File or in the Get Enrollment real time Application Programming Interface (API). Because the FFE sends BAR transactions before the OEP, the FFE sends the majority of active re-enrollments for QIs who keep their re-enrollment plan as M834 transactions. If a re-enrollee updates their future-year application and keeps the same 14-character plan ID, removing or changing the subscriber will send the update as a CANCELCIC cancellation. The FFE also sends CANCELCIC cancellations for any passive re-enrollments when enrollees subsequently change plan IDs during active plan selections before December 15.

The FFE sends an initial enrollment to the issuer of the new plan the QI actively selected, which includes eligibility updates, if applicable. An issuer that receives a cancellation of a passive re-enrollment should not renew the enrollment unless the enrollee has actively renewed coverage with the issuer, causing an active re-enrollment transaction to be sent. In most situations where an enrollee has been passively re-enrolled but then makes a plan selection change with an effective date after January 1, the FFE will terminate their passive re-enrollment effective the day before the actively selected plan becomes effective. For example, an enrollee eligible for a Loss of MEC SEP (ending March 1) because the current-year product is no longer available to them may make a plan selection change on January 2. The issuer of the auto re-enrolled policy would receive a termination transaction effective January 31, and the issuer of the newly selected plan would receive a February 1 enrollment transaction. In no case does a plan selection for the future plan year send a termination transaction to the current-year issuer for current-year coverage.

If an enrollee actively re-enrolls for the next plan year before the FFE sends their auto re-enrollment transactions, the FFE will not send a passive re-enrollment transaction. If an enrollee who has not been auto re-enrolled actively enrolls with a different issuer for the next plan year, the Exchange will list the

subscriber on the Switch File, sent daily from the beginning of the OEP to mid-December, to the enrollee's current issuer. The FFE provides this list of current-year subscribers who have actively switched issuers for the next plan year to inform current-year issuers to non-renew the listed subscribers' enrollments. See **Section 3.4.1**, **Enrollee Switch File**, for additional information.

3.3.1 Identifiers on Enrollment Transactions

The identifiers on enrollment transactions are as follows:

- The FFE-assigned subscriber ID and member ID, also known as Exchange-Assigned Subscriber ID and Exchange-Assigned Member ID, respectively, remain the same for enrollees choosing the same issuer (i.e., five-digit Health Insurance Oversight System [HIOS] ID) for the next plan year.
- FFE application IDs and FFE policy numbers are new for all future-year plan selections, whether active or passive.
- The FFE does not send information for assisters who are not A/Bs on passive re-enrollments.
- The FFE sends information for all types of assisters (e.g., Navigators and Certified Application Counselors [CACs]) on active re-enrollments according to existing procedures.
- If recorded on the current plan year's application, the FFE sends the A/B's National Producer Number (NPN) on passive re-enrollments. For an active re-enrollment, the NPN from the current year is pre-populated on the future-year application if the NPN is already associated with the current-year application but can be removed or edited by the applicant. **Exhibit 10** illustrates the rules governing how to send NPNs.

Exhibit 10: NPN Rules

Scenario	NPN on Current-Year Enrollment Transaction	NPN on 1000c Loop on Future-Year 834 Enrollment Transaction
Passive re-enrollment (auto re-enrollment) of QI whose FFE policy is associated with NPN before mid-October	123	123
Passive re-enrollment (auto re-enrollment) of QI whose FFE policy is updated with NPN after auto re-enrollment	123	None – At the time BAR auto-renewed the member, there was no NPN to carry forward.*
Active re-enrollment by returning QI who updates future-year application and is able to view and edit current-year A/B information but does not change or remove A/B information	456	456 – The A/B information from the current-year application is pre-populated on the future-year application.**

Scenario	NPN on Current-Year Enrollment Transaction	NPN on 1000c Loop on Future-Year 834 Enrollment Transaction
Active re-enrollment by returning QI who removes A/B information on future-year application	789	N/A – A QI removed the A/B information on the future-year application.

***NOTE**: NPNs received after the first BAR wave through Enrollment Data Reconciliation are relayed to issuers in the second BAR wave.

****NOTE**: If the most recent version of the QI's current-year application includes the NPN, the NPN will pre-populate on the future-year application. If the NPN is not included on the most recent version of the current-year application, the NPN will not pre-populate on the future-year application. This is particularly important for DE Entities using the DE QI Flow, who only submit the NPN via the Submit Enrollment Request but do not include the NPN on the application. NPNs submitted via the Submit Enrollment Request are only written to the QI's policy, not the application. This highlights the importance of DE Entities assisting their clients with the re-enrollment process.

Exhibit 11 illustrates re-enrollment transaction scenarios and their associated MRC, FFE subscriber IDs, and whether the issuer should send an effectuation transaction to the FFE.

Exhibit 11: Re-enrollment Transaction Illustration

Scenario	834 MRC	FFE Subscriber ID	New Policy and Application ID Assigned?	Send Effectuation to FFE?	Collect Binder from Enrollee?
Auto re-enrollment (passive) – A current enrollee does not return to the FFE to update eligibility and plan selection. The issuer renews their coverage as indicated on the Plan ID Crosswalk Template.	INS04 – 41	Same	Yes	No	No
Active re-enrollment – A current enrollee returns to the FFE by December 15 to actively apply and enroll in future-year coverage. The enrollee reselects the current year's product for the future year. The FFE cancels the enrollee's passive re-enrollment by sending the initial enrollment transaction.	INS04 – EC	Same	Yes	No	No
Active switch after auto re-enrollment – A current enrollee returns to the FFE by December 15 to actively apply and enroll in future-year coverage with a different issuer. The FFE cancels the enrollee's passive re-enrollment. Because the enrollee switched to a different issuer, the enrollee appears on the Switch File[17] so that the current-year issuer will not renew the enrollee's coverage.	INS04 – EC	New	Yes	Yes	Yes

[17] The Switch File is an electronic file delivered separately for each issuer offering plans through the FFE to identify the issuer's current subscribers who have actively re-enrolled in next-year coverage offered by a different issuer.

Scenario	834 MRC	FFE Subscriber ID	New Policy and Application ID Assigned?	Send Effectuation to FFE?	Collect Binder from Enrollee?
Active switch before auto re-enrollment – A current enrollee returns to the FFE on November 1 to actively enroll with a different issuer, before the enrollee could be passively re-enrolled. The FFE does not send a passive re-enrollment because the enrollee is already actively enrolled. There is no passive re-enrollment for the FFE to cancel; however, the enrollee will appear on the Switch File so that the current-year issuer will not renew the enrollee's coverage.	INS04 – EC	New	Yes	Yes	Yes
Auto re-enrollment (passive) followed by active CIC during the OEP – A current enrollee is passively re-enrolled effective January 1 during the first BAR wave. Because the enrollee was in the opt-out group and failed to update their eligibility information, the QI is enrolled with no APTC. On December 14, the enrollee returns to the FFE to report updated eligibility information due to a CIC and is determined eligible for APTC. The enrollee reselects the same plan, with the updated information taking effect January 1. The FFE sends a maintenance 834 transaction (M834) reflecting the update.	• January 1 M834 (APTC update): INS04 – NULL (FINANCIAL CHANGE)	• Same	• No	• No	• No

Scenario	834 MRC	FFE Subscriber ID	New Policy and Application ID Assigned?	Send Effectuation to FFE?	Collect Binder from Enrollee?
Auto re-enrollment (passive) followed by active CIC after the OEP – A current enrollee is passively enrolled effective January 1 during the first BAR wave. Because the enrollee was in the opt-out group and failed to update their eligibility information, the QI is enrolled with no APTC. On December 18, the enrollee returns to the FFE to report updated eligibility information due to a CIC and is determined eligible for APTC. The enrollee reselects the same plan, with the updated information taking effect February 1. The FFE sends the passive re-enrollment effective January 1 and a February 1 M834 transaction reflecting the updated APTC.	• January 1 initial (no APTC): INS04 – 41 • February 1 M834 (with APTC): INS04 – NULL (Financial change)	• Same • Same	• Yes • No	• No • No	• No • No

Exhibit 12 illustrates an example of multiple transactions for a single enrollment where the same enrollee visits HealthCare.gov on three separate occasions.

Exhibit 12: Multiple Transactions for a Single Enrollment

Transaction Date	December 16	December 18	January 2
Description	Passive re-enrollment sent	QI changes plan	QI reports a life change
Key 834 Codes	• Origin Type – 11 (Auto Re-enrollment) • MRC – 41	• Origin Type – 1 (FFE Online) • MRC – EC Straight term/initial (not CIC)	• Origin Type – 1 (FFE Online) • MTC – 001 (Subscriber) Maintenance Enrollment Transaction
Electronic Data Interchange (EDI) Functional Code	I834AR	I834	M834

For detailed transaction requirements, issuers should continue to consult the CMS X12 834 Companion Guide, which is available on CMSzONE at https://zone.cms.gov/document/834-enrollment-0.

3.3.2 CSR and APTC Calculations on Passive Re-enrollments

For an enrollee who does not contact an Exchange on the Federal eligibility and enrollment platform 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 in accordance with the effective dates specified at 45 CFR 155.410(f) or 155.420(b), as applicable, the Exchange will establish eligibility for the upcoming plan year as specified in the Guidance on Annual Redetermination and Re-enrollment for Marketplace Coverage for 2024 and Later Years.[18] Enrollees who actively return to the Exchange to submit updated eligibility information for future-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).

3.4 Additional Files and Transactions to Support Issuers with Auto-Renewal

The FFE communicates the majority of renewals (both active and passive) and new enrollments to issuers via 834 enrollment transactions. Because of the unique data architecture of the Exchange, issuers also receive additional files and transactions informing the issuers of FFE enrollments. For example, the Switch File (**Section 3.4.1**) tells the current-year issuer to end coverage on December 31 and that no auto re-enrollment should be expected, while the Passive Cancel Job (**Section 3.4.2**) eliminates duplicate coverage created in error. The Cancel Carry Forward job (**Section 3.4.3**) cancels

[18] See Guidance on Annual Redetermination and Re-enrollment for Marketplace Coverage for 2024 and Later Years at https://www.cms.gov/files/document/guidance-annual-redetermination-and-re-enrollment-marketplace-coverage-2024-and-later-years.pdf.

auto-renewals in situations where eligibility for auto-renewal ended because the associated current-year policy terminated after BAR.

3.4.1 Enrollee Switch File

When an enrollee whose policy is in current (not cancelled or terminated) status completes an active re-enrollment for future-year coverage in a plan offered by a different issuer from the current-year issuer, the FFE does not send the current-year issuer an 834 termination transaction. Rather, for enrollees for whom the FFE has already sent passive re-enrollments, the current-year issuer receives a cancellation for the future-year passive enrollment, which is the signal to non-renew coverage unless another enrollment transaction is received. However, for enrollees who actively switch issuers for the new plan year and for whom no passive enrollment has been sent, there is no passive re-enrollment to cancel.

To address this, the FFE produces an electronic file for each issuer offering plans through the FFE that identifies the issuer's current subscribers who have actively re-enrolled in future-year coverage offered by a different issuer. The FFE generates the file daily beginning shortly after the start of the OEP until around the cutoff for January coverage. Each Enrollee Switch File (sent with the EFT function code SWTFL) 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. Only subscribers who have not been auto re-enrolled and actively switch issuers for the future plan year are candidates for the Switch File.

An enrollment group's presence on the Switch File signals to the issuer that the coverage will not be renewed into the new plan year via BAR. As there is no current BAR policy in the new plan year for enrollment groups appearing on the Switch File, no action is required of the issuer in terms of Enrollment Data Alignment (EDA).

Issuers are to take whatever action is necessary to non-renew coverage in their system but should not submit an IC834 termination transaction nor report the policy as terminated on the RCNI file simply due to presence on the Switch File.

If an enrollee who has switched issuers for the future year subsequently switches back to a plan offered by their current-year issuer, that enrollee will be removed from the next Switch File. A QDP subscriber will appear on the Switch File if the current subscriber either actively enrolled in a QHP while declining QDP coverage for the future plan year or if the QDP subscriber actively switched to a different QDP issuer.

Exhibit 13 summarizes the Enrollee Switch File fields.

Exhibit 13: Enrollee Switch File Field Descriptions

Category	Fields
Previous-Year (Current-Year) Plan Information	• Issuer Assigned Subscriber ID • Application ID • HIOS ID • Plan ID • Line of Business • TPID

Category	Fields
Subscriber Information	• FFM Subscriber First Name • FFM Subscriber Last Name • FFM Subscriber DOB (Date of Birth) • FFM Subscriber SSN (Social Security Number) • FFM Assigned Policy ID
Last Modified Data on Current- and Future-Year Policies	• Last Modified [COVERAGE_YEAR_PREV] Policy Date • Last Modified [COVERAGE_YEAR] Policy Date • Last Modified [COVERAGE_YEAR] Application Date

3.4.2 Passive Cancel Job

When enrollees or their assisters fail to access their existing pre-populated future-year application and instead create a new application for future-year coverage, a duplicate policy is created. The FFE cancels passive re-enrollments that duplicate active enrollments for future-year coverage via the Passive Cancel job. This job runs periodically in November and December. Issuers receive these files in IPA layout via EFT function code BARCNX. These enrollments have already been cancelled by the FFE, and the issuers should similarly cancel the policies in their records. From January until the next OEP, the overlap cleanup job performs deduplication, which is visible on the Pre-Audit File.

For more information on these files, including recommended issuer actions, refer to the latest version of the *Standard Issuer Enrollment Data Files* document, available on CMSzONE at https://zone.cms.gov/document/enrollment-data-reconciliation.

3.4.3 Cancel Carry Forward Job

During the OEP, an enrollee or issuer may terminate (or cancel) current-year coverage after the FFE has sent the passive re-enrollment for future-year coverage, (e.g., terminations for non-payment). The Cancel Carry Forward job cancels auto re-enrollments (policy origin of 11) that are linked to a prior-year enrollment that has been cancelled or terminated after auto-renewal. Because the passive re-enrollments were created based on the prior year's coverage, which subsequently ended, the Cancel Carry Forward job "carries forward" the termination (or cancellation) to cancel the future year's enrollment.

Generally, auto re-enrolled policies are terminated (or cancelled) on the same day that the current year policy terminates. However, as an exception, issuer-submitted terminations (or cancellations) in EDA need the Cancel/CIC Cancel Carry Forward to cancel the auto re-enrolled policy.

The FFE sends I834 cancellations with an AMRC of CANCEL-CARRYFORWARD periodically from November through March to cancel future-year auto-renewals associated with prior-year policies that terminated or cancelled after BAR. Issuers should review the cancellations documented in the file and ensure the cancellations are applied to the appropriate passive re-enrollments in their system, taking care to cancel using the FFE policy ID (not the subscriber ID). Issuers will see these cancellations reflected in the Enrollment Pre-Audit (AUD) Files.

If the issuer makes a subsequent determination to reinstate the prior-year enrollment (e.g., reverse a cancellation/termination for nonpayment of premiums), the issuer must also review the auto re-enrollment that was cancelled by the Cancel Carry Forward job for reinstatement. CMS caseworker approval is not needed to reinstate cancelled passive re-enrollments for future-year coverage triggered by issuer-initiated terminations/cancellations of the prior-year enrollment that are later reversed by the issuer.

3.4.4 BAR Progress Report

In the run up to and throughout the OEP, the FFE sends QHP and QDP issuers that are expecting renewals (i.e., issuers continuing to offer QHPs through the Exchange) a daily report that totals the auto-renewals as of midnight the night before the report's generation using EFT function code BARPGX. The report compares the count of BAR-eligible policies (current-year policies in good standing as of that incremental run of BAR, updated periodically throughout the OEP) with the BAR enrollments sent by the FFE. Issuers can use the report to track progress and report problems. For example, the issuer may realize from a lower-than-expected BAR-eligible count that the issuer accidentally terminated enrollments and will need to seek reinstatements.

Exhibit 14 summarizes the BAR Progress Report fields and definitions.

Exhibit 14: BAR Progress Report Field Descriptions

Field Name	Description
bar_eligible_policies	Current year coverage in initial or effectuated status with 12/31 Plan Benefit End Date and EOY (end-of-year) is False (excludes current year policies with active future year re-enrollments).
regular_auto_reenrolled	Total count to date of future year auto-renewals (policy origin is 11 and current year and future year HIOS IDs match).
estimated_alternate_enrollments	Estimate of new policies estimated by CMS to be matched to the issuer. **NOTE**: This only applies to issuers who were notified by CMS.
alternate_enrollments	The count of alternate enrollments (number of policies) sent to date (policy origin is 11 and current year and future year HIOS do not match).

Issuers should note that the report provides estimates, which may not equal the total BAR files they receive. Issuers are encouraged to review the following guidance before opening a ticket with the Marketplace Service Desk (MSD):

- Compare future-year subscribers with current-year subscribers using the FFE Member ID and other unique identifiers. In rare circumstances, the subscriber might change, but the FFE Member ID will remain the same.
- Current-year enrollments created after October 1 will not BAR until the incremental BAR wave in November.
- To be eligible for BAR, an enrollment must show as current in the FFE. Issuers should check the most recent Pre-Audit File in the System of Exchange Enrollment Data (SEED) to verify if the policy is current with the FFE.

If issuers still have concerns that an auto re-enrollment was not received, the issuer may contact the MSD at CMS_FEPS@cms.hhs.gov and provide 3-5 sample current-year application/enrollment IDs of policies that have not been auto-renewed with an explanation of the concern.

3.4.5 Effectuation at Re-enrollment and CIC

Issuers do not need to send the FFE an effectuation transaction for any previously effectuated passive or active (with the same issuer as identified by the five-digit HIOS ID) re-enrollment as long as the enrollment has the same FFE-assigned subscriber ID for both plan years. Similarly, issuers need not send effectuations when an enrollee selects a plan in the same product in an enrollment update reported through a CIC. However, effectuation confirmation transactions and binder payments are required for enrollments with a new subscriber, such as an adult child being re-enrolled as a new subscriber in a passive re-enrollment age-off scenario. Issuers must also send effectuation confirmation transactions and collect binder payments for active enrollments for new enrollees and for returning enrollees who did not have continuous coverage.

3.4.6 Life Changes During the OEP

An enrollee can report life changes triggering CIC transactions to issuers for both current-year and future-year coverage during the OEP. If reported to the FFE by December 15, changes to current-year coverage, such as the addition of a baby or spouse, are reflected on the passive re-enrollment for future-year coverage. After December 15, the enrollee cannot initiate changes to current-year coverage in self-service mode on HealthCare.gov but must instead contact the Marketplace Call Center. Enrollees who actively selected future-year coverage by December 15 and subsequently want to update their current-year coverage based on a CIC should contact the Marketplace Call Center. The Marketplace Call Center can assist enrollees in updating their applications and coverage for both the current and future year, if necessary.

3.4.7 Tobacco Rating at Time of Re-enrollment

For passive re-enrollments, the FFE uses the tobacco status from the current year. In rare cases of technical error during passive enrollment, a policy may have an incorrect rating for tobacco status. Issuers can restore a tobacco status inadvertently changed during passive re-enrollment through the Enrollment Data Reconciliation process (see **Section 9.3**, **Enrollment Data Reconciliation and Pre-Audit Files**).

During the OEP or an SEP, enrollees can actively update their enrollment to change their last date of tobacco use 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. Issuers should honor tobacco status changes made actively during an OEP or SEP.

3.4.8 Medicare Enrollment and Non-Renewals

Section 1882(d)(3)(A)(i)(I) of the Social Security Act (SSA) (the Medicare anti-duplication provision) prohibits issuers, A/Bs, and web-brokers who know a QI is entitled to Medicare Part A or enrolled in Medicare Part B from selling or issuing individual health insurance coverage that duplicates[19] the QI's

[19] See Section 1882(d)(3)(A)(iv) of the SSA (providing that a health insurance policy, other than a Medicare supplemental policy, that provides benefits that are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to "duplicate" for purposes of the Medicare anti-duplication provision).

Medicare or Medicaid benefits. The Medicare anti-duplication provision is intended to protect Medicare beneficiaries from fraudulent or abusive practices leading to the purchase of excessive or unnecessary coverage. Employer-sponsored coverage is explicitly exempt from the Medicare anti-duplication provision.[20]

Sections 2703 and 2742 of the Public Health Service Act, and promulgated regulations at 45 CFR 147.106 and 148.122, generally require guaranteed renewability of coverage for employers and individuals in the group and individual health insurance markets. Until 2017, the guaranteed renewability regulations did not include Medicare eligibility or entitlement as a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market. However, the Notice of Benefit and Payment Parameters for 2018[21] proposed and finalized a regulatory interpretation of Medicare anti-duplication and guaranteed renewability provisions, which prohibits issuers that have knowledge that an enrollee in individual health insurance coverage is entitled to Medicare Part A or enrolled in Medicare Part B from renewing the individual health insurance coverage if the coverage would "duplicate" Medicare or Medicaid benefits to which the enrollee is entitled, unless the renewal is effectuated under the same policy or contract of insurance. State insurance rules determine when a change in policy or contract of insurance has occurred.

QHP issuers that have knowledge that an enrollment covers a QHP enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B must non-renew the entire policy if the QHP re-enrollment plan is a different policy or contract of insurance and the new coverage "duplicates" Medicare or Medicaid benefits to which the enrollee is entitled. [22] The issuer should send a termination transaction to the FFE ending coverage as of December 31 with an AMRC of TERM-ANTIDUPLICATION (CANCEL-ANTIDUPLICATION on the future-year policy is also acceptable) near the end of the plan year.

A QHP issuer should not presume that all individuals aged 65 or older are entitled to Medicare Part A or enrolled in Medicare Part B. QHP issuers must send a termination notice, pursuant to 45 CFR 155.430(b)(2)(i) and 156.270(b)(1), to any enrollee whose coverage has not been renewed due to an enrollee in the enrollment group being entitled to Medicare Part A or enrolled in Medicare Part B. The termination notice should advise the individual(s) on the policy whose coverage was terminated and who is not entitled to Medicare Part A and not enrolled in Medicare Part B that they will be eligible for an SEP and to actively re-enroll in another policy for continued coverage, making the Medicare enrollee a non-applicant. The Marketplace Call Center will have lists of enrollees eligible for the SEP, and enrollees will not be required to submit documentation, as the circumstances were already verified. Refer to **Section 5**, **Special Enrollment Periods (Applicable to the Individual Market FFE, QHPs/QDPs)**, for information on SEPs.

Enrollees who become entitled to Medicare Part A or enrolled in Medicare Part B after enrolling in coverage through the Exchange may maintain coverage until the coverage is lawfully terminated in accordance with the Medicare anti-duplication provision, as described previously, or otherwise. However, the QI loses eligibility for APTC and CSR when the enrollee becomes eligible for or enrolled in Medicare Part A or Medicare Part C (otherwise known as Medicare Advantage), as determined by IRS regulations. QHP issuers are encouraged to ask enrollees who are newly entitled to Medicare Part A or enrolled in Medicare Part B if they wish to maintain coverage in a QHP. Issuers

[20] See Section 1882(d)(3)(C) of the Social Security Act (SSA).
[21] 81 FR 94058
[22] See *Final HHS Notice of Benefit and Payment Parameters for 2018* (81 FR 94058).

are also encouraged to provide instructions about how such enrollees can report a change to the Exchange to terminate coverage or stop receipt of APTC and CSR to reduce the burden of repaying some or all of the APTC received (during months of overlapping coverage) when filing their annual Federal income taxes.

For additional operational guidance regarding termination or nonrenewal transactions for Medicare beneficiaries, refer to the annually published OEP transaction summary guidance available on REGTAP. For additional policy and technical guidance regarding the Medicare anti-duplication process, refer to the 2024 Open Enrollment Medicare Non-Renewal Operations presentation. For guidance regarding benefit coordination when an individual is eligible for but not enrolled in Medicare, refer to https://www.cms.gov/files/document/benefit-coordination-and-medicare-eligibility.pdf.

3.4.9 Cancelling BAR Policies in Passive Status (Unwanted BAR)

Enrollees are free to cancel a passive re-enrollment at any time after the passive re-enrollment is sent to the issuer, as long as the cancellation is for the entire policy. Cancellation requests can be made through the Marketplace Call Center or directly with an issuer. The cancellation must be for the entire policy, and issuers must grant the enrollee's request regardless of whether claims have been filed. Enrollees may also request cancellation for prior years, which issuers must grant as long as the enrollment is still in passive status. If the enrollment was initially a passive status but the consumer made an active selection resulting in a new segment of the same policy, the policy is no longer considered to be in passive status, and cancellation requests for these policies cannot be granted, unless otherwise permitted. Issuers should report cancellations received directly from an enrollee via IC834 or monthly Enrollment Data Reconciliation.

Additionally, retroactive and prospective adjustments to segments within a policy that originated as a passive enrollment but were actively modified by the consumer are generally not permitted. For example, if a consumer is passively re-enrolled into coverage and updates their application and reselects the same QHP such that a new segment is created, the new segment may not be made retroactive to the start date of the original segment within the same policy. Similarly, the original segment start date may not be adjusted forward within the same policy.

3.4.9.1 Examples

Example 3A: A consumer is enrolled in a plan that is covered 100% by APTC. Since the consumer has a new job and will be enrolled in employer-sponsored coverage for the upcoming plan year, the consumer mistakenly believes their Marketplace coverage will automatically be cancelled. In January, the consumer realizes they were re-enrolled in Marketplace coverage for the new plan year and calls the issuer to request cancellation of their current policy. The issuer reviews the request, and because the enrollment is still in passive status, the issuer grants the enrollee's request and sends the Marketplace a cancellation via IC834.

Example 3B: A consumer is auto re-enrolled into the same plan for the upcoming plan year. In February, the consumer updates their application and is found eligible for Medicaid retroactively to January 1 and wants to cancel their auto re-enrolled plan for the current plan year since they no longer need it. The consumer calls their issuer to request a cancellation, but since the consumer actively updated their application in February and the enrollment is no longer in a passive status, the issuer must deny the enrollee's request. The issuer submits a plan request to CMS and the caseworker reviews the request for cancellation. The caseworker assesses if the consumer is eligible for the

requested cancellation based on the date of the enrollee's first call or any allegation of misrepresentation. In this example, the caseworker denies the request and sends prospective termination instructions to the issuer based on the date the enrollee contacted the call center. The issuer submits changes via EDA.

Example 3C: An issuer receives a call from a consumer who reports that they didn't realize they had been re-enrolled in Marketplace coverage for the past two plan years. Since the consumer was also enrolled in employer-sponsored coverage during that time, they ask the issuer to cancel the past two years of Marketplace coverage. The issuer sees that claims have been filed on one of the policies, but both remain in passive status. Despite the presence of claims, the issuer grants the enrollee's request to cancel coverage two years retroactively and sends the FFE a cancellation via IC834. If the issuer is attempting to cancel a policy for a prior year after the IC834 cutoff date, they should utilize an EDA channel to cancel the prior year policy.

3.4.10 Post-BAR Reinstatements

The FFE sends impacted issuers a list of enrollments where the current-year coverage was reinstated by the issuer using EDA channels after BAR concluded, and there is no apparent active future-year re-enrollment. These enrollees are flagged for SEPs at the Marketplace Call Center, and issuers are encouraged to conduct outreach. The FFE delivers the files from January through March, with a function code of IOUTRC.

4. DIRECT ENROLLMENT (APPLICABLE TO THE INDIVIDUAL MARKET FFE, QHPS/QDPS)

4.1 Introduction

Direct Enrollment (DE) is an enrollment process that allows new applicants and existing enrollees to enroll in a Qualified Health Plan (QHP),[23] either directly with a QHP issuer or through a Federally-facilitated Exchange (FFE)-registered web-broker in a manner considered to be through the FFE, during an Open Enrollment Period (OEP) or Special Enrollment Period (SEP), when the process is originated through either a CMS-approved QHP issuer website or CMS-approved web-broker website (referred to as DE Entity websites). Enrollees also have the ability to report life changes through DE. Consumers may use DE with or without the assistance of an FFE-registered agent or broker (A/B).

Currently, the FFE offers two different options for QHP issuers and web-brokers who wish to participate in DE (referred to as DE Entities). First, there is the classic DE pathway, which is also known as the double-redirect pathway. Second, there is the Enhanced DE (EDE) pathway. References to "DE" in this manual without specifying either classic DE or EDE, are inclusive of both the classic DE and EDE pathways. As of 2025, CMS began phasing out the classic DE pathway. Currently, only DE entities that do not have access to EDE are permitted to continue conducting enrollments and application updates via the classic DE pathway; however, the classic DE pathway will be retired in advance of open enrollment for plan year 2027.

Retirement of Classic DE Pathway

Over the past several years, CMS has noted a decreasing number of consumer enrollments processed through the DE Classic pathway and a large increase in utilization of the EDE pathway and enrollments processed directly through HealthCare.gov. Aiming to continue CMS's goal of modernizing systems and efficiently utilizing resources when providing consumers with both adequate and affordable insurance coverage, CMS has decided to retire the DE Classic enrollment pathway in advance of open enrollment for plan year 2027.Sunsetting DE Classic will streamline future Marketplace changes by removing the need for teams to account for changes necessary to the currently underutilized DE Classic pathway. This will further increase the efficiency of current Marketplace resources by allowing teams to focus efforts on the enrollment pathways that are preferred by both the consumers and CMS's external partners.

Classic DE Pathway (Available until October 2026)

The classic, or double-redirect, DE pathway utilizes Security Assertion Markup Language (SAML) to securely transfer a qualified individual (QI) or A/B from a DE Entity's website to HealthCare.gov, where the QI completes the FFE's eligibility application. Once the eligibility application has been completed, the QI or A/B is securely redirected back to the DE Entity's website for plan selection and enrollment. DE Entities then use Extensible Markup Language (XML) Application Programming Interfaces (APIs) to obtain a QI's eligibility results and submit the QI's enrollment to the FFE. The

[23] 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 FR 18310, 18315) (March 27, 2012), with some limited exceptions, Qualified Dental Plans (QDPs) are considered a type of QHP. Unless indicated otherwise, references to QHPs in Section 4 include QDPs.

APIs include the Fetch Eligibility service, which allows a DE Entity to obtain a QI's eligibility results, and the Submit Enrollment service, which allows a DE Entity to submit a QI's enrollment to the FFE.

Technical specifications for the SAML, Fetch Eligibility, and Submit Enrollment services are outlined in both the *FFE DE API for Web-Brokers/Issuers Technical Specifications* and the *Federal Data Services Hub (DSH) DE Business Service Definitions (BSDs)*, both of which can be found on CMSzONE at https://zone.cms.gov/document/direct-enrollment-de-documents-and-materials.

EDE Pathway

The EDE pathway, unlike the classic DE pathway, does not require a QI to be redirected to HealthCare.gov to complete the eligibility application. Instead, DE Entities that use the EDE pathway are able to provide a complete enrollment experience on their websites, including hosting the eligibility application. While DE Entities can host the eligibility application on their sites for EDE, eligibility determinations are still made by the FFE. DE Entities participating in EDE utilize a suite of JavaScript Object Notation (JSON) APIs that the FFE makes available to obtain eligibility results from the FFE, create and update QI eligibility applications, obtain QI notices, and submit verification documentation, among other things. The XML Submit Enrollment API used for classic DE is also used for EDE. Technical specifications for the EDE APIs can be found on CMSzONE at https://zone.cms.gov/document/enhanced-direct-enrollment-ede-documents-and-materials.

The plan shopping experience for both DE pathways, including the display of available plans, selection of advance payments of the premium tax credit (APTC) amounts (for those who are eligible), and the submission of plan selections, is implemented by the DE Entity on its website and in accordance with applicable CMS requirements.

DE Entities that wish to access CMSzONE links can do so by creating a CMS Enterprise Portal account at https://portal.cms.gov (if one has not been created already). Once an account has been created, the user must request access to CMSzONE via their CMS Enterprise Portal account. Once access to CMSzONE is approved, the user can access the links by logging into https://zone.cms.gov with their CMS Enterprise Portal account login.

QHP issuers and web-brokers that are interested in participating in DE should send any questions to DirectEnrollment@cms.hhs.gov.

4.2 Guidelines for Specific QI Scenarios

The FFE provides eligibility results to DE Entities for those individuals seeking coverage through the DE Entity's website. The FFE also provides information about whether each applicant using the DE Entity's website is eligible for enrollment in a QHP through the FFE. When the applicant has applied for financial assistance, the FFE makes a determination of eligibility for APTC and cost-sharing reduction (CSR) and performs an assessment or determination of eligibility for Medicaid and/or the Children's Health Insurance Program (CHIP), depending on the state's election.

4.2.1 Applicant Not Eligible for QHP Enrollment

If an applicant using DE is determined ineligible for enrollment in a QHP through the FFE, this information will be provided to the applicant and DE Entity, and the DE Entity will review the determination with the applicant. The applicant can then view and select a plan offered outside the FFE, if desired.

4.2.2 Applicant Is Eligible for QHP Enrollment and APTC/CSR

If an applicant using DE is found eligible for enrollment in a QHP through the FFE and is determined eligible for APTC or CSR, this information will be provided to the applicant and DE Entity, and the DE Entity will review the information with the applicant. DE Entities must provide applicants who are eligible for APTC with the option to select the amount of APTC they want to apply towards the reduction of their share of the premiums during the plan selection process. For applicants eligible for income-based CSR, a DE Entity should only display the CSR plan variant that an individual is eligible for when displaying any Silver QHP, or any metal level QHP for enrollees eligible for CSR due to their status as either a member of a Federally recognized Indian tribe or Alaska Native Claims Settlement Act (ANCSA) Corporation Shareholder.

4.2.3 Applicant Is Eligible for QHP Enrollment but Not for APTC/CSR

If an applicant using DE is found eligible for enrollment in a QHP through the FFE but is determined ineligible for APTC or CSR, this information will be provided to the applicant and DE Entity, and the DE Entity will review the information with the applicant. During subsequent plan selection, the DE Entity should not include any APTC amount for an applicant who is not eligible for APTC or display CSR plan variations for an applicant who is not eligible for CSR.

4.2.4 Applicant Assessed or Determined Eligible for Medicaid or CHIP

Modified Adjusted Gross Income (MAGI)-based Medicaid/CHIP Eligibility Scenario: If an applicant using DE is assessed as potentially eligible or determined eligible for MAGI-based Medicaid or CHIP, the FFE sends the applicant's information to the state Medicaid or CHIP agency via account transfer (AT), for a final eligibility determination and/or enrollment, as applicable. The applicant and DE Entity will be informed of the applicant's Medicaid and CHIP eligibility status based on the FFE's evaluation, and the DE Entity will review the information with the applicant. The state agency will subsequently follow up with the applicant. The applicant may also contact the state Medicaid or CHIP agency regarding their application/enrollment status. In some cases, the state may ask the applicant to provide additional information. As applicable, the applicant should respond timely to these requests so that the state can complete an eligibility determination/enrollment in Medicaid or CHIP coverage.

Applicants who are assessed by the FFE as potentially eligible or determined eligible for MAGI-based minimum essential coverage (MEC) Medicaid or CHIP will not be eligible for enrollment into a QHP on a financial assistance application. If such applicants are interested in enrolling in a full-cost QHP, they can create and submit a separate non-financial assistance FFE application by calling the Marketplace Call Center. The DE Entity should not include those applicants who are assessed or determined eligible for MAGI-based MEC Medicaid or CHIP in an enrollment group on a financial assistance application because the DE Entity will receive an error during the enrollment submission; the system can only accept a submitted enrollment for applicants who are marked as eligible for enrollment into a QHP. Consumers referred to the state by the FFE on a non-MAGI Medicaid basis who are awaiting a final eligibility determination from the state are eligible to enroll in QHP with APTC, if otherwise eligible, until/unless they are found eligible by the state for MEC Medicaid on a non-MAGI basis.

If an applicant assessed by the FFE as potentially eligible for MEC Medicaid or CHIP is ultimately determined ineligible for MEC Medicaid or CHIP by the state agency, the state agency will transfer the applicant's account information back to the FFE, and the applicant will be sent a notice (see sample

Outbound Response AT notice at https://www.cms.gov/marketplace/in-person-assisters/applications-forms-notices/notices) from the FFE with instructions on how the applicant may update and submit their FFE application in order to receive a determination of eligibility for QHP coverage through the FFE and for APTC and CSR. Applicants can update and submit their FFE application either to the DE Entity or directly to the FFE. Consumers who initially applied for coverage through the FFE during open enrollment or an SEP due to a qualifying life event, were assessed by the FFE as eligible for MEC Medicaid or CHIP, and later—after open enrollment has ended or their SEP has ended—receive a final determination from the state that they are not eligible for Medicaid and CHIP, can qualify for an SEP to enroll in FFE coverage. This SEP automatically provides consumers with a prospective coverage start date. Consumers can also call the Marketplace Call Center to request a retroactive coverage effective date back to the QHP coverage effective date they would have received if the FFE had originally determined them eligible for QHP coverage.

Non-MAGI-based Medicaid Eligibility Scenario: On a financial assistance application, the FFE will evaluate applicants' eligibility for Medicaid based on factors other than MAGI (i.e., disability, long-term care needed, applicants aged 65 and older). If any of these factors appear to apply based on answers to the FFE application questions, the applicant's account information will be sent to the state for a final eligibility determination on a non-MAGI basis. If an applicant indicates on the FFE application that one or more of the non-MAGI factors apply and is determined eligible for enrollment in a QHP through the FFE, then the applicant and DE Entity will be informed that the applicant is eligible to select a QHP through the FFE. In this scenario, the applicant can opt to select and enroll in a QHP while they wait for the state to make a non-MAGI Medicaid eligibility determination. If the applicant is eligible for APTC or CSRs, pending the outcome of the non-MAGI determination, the amount of APTC or CSRs available will be provided to the applicant and DE Entity and should be used during the subsequent plan selection process. If the applicant is found eligible for enrollment into a QHP with APTC or CSRs and the state later determines them eligible for non-MAGI Medicaid that counts as MEC, the applicant is no longer eligible for APTC or CSRs. For information on when and how to end FFE coverage when a consumer gets MEC Medicaid or CHIP, visit https://www.healthcare.gov/how-to-cancel-a-marketplace-plan/.

If the FFE does not identify an applicant for a non-MAGI based referral to the state agency, the applicant can request an eligibility determination by the state on a non-MAGI basis.

4.2.5 Households that Include QIs Eligible for Different Coverage Programs

For households that include individuals eligible for different coverage programs (e.g., QHP with APTC, Medicaid), DE Entities should follow the guidelines outlined previously for each applicant in the household. When an applicant is determined eligible or assessed as potentially eligible for Medicaid or CHIP based on MAGI or non-MAGI (e.g., disability, long-term care needed, applicants aged 65 and older) circumstances, the FFE will transfer application information to the state Medicaid or CHIP agency, as applicable. DE Entities should not include any applicants in the QHP selection process who are not listed as eligible for enrollment in a QHP through the Exchange, since the DE Entity would receive an error during the enrollment submission due to the fact that the system can only accept an enrollment request for applicants that are marked as eligible for enrollment into a QHP.

DE Entities have the ability to create their own shopping experience on their websites, subject to applicable CMS requirements. Nevertheless, if a household has applicants who are determined eligible for QHP enrollment through the FFE and others who are not eligible, the DE Entity website must first

complete the plan selection process for applicants eligible for QHP enrollment through the FFE prior to completing the plan selection process for individuals who are not eligible for QHP enrollment through the FFE. While the DE Entity may not enroll applicants in Exchange coverage who are determined ineligible for QHPs, the DE Entity may enroll them in coverage outside the Exchange after completing the enrollment process for those applicants who are QHP-eligible.

4.3 Enrollment Groups

Due to system limitations, DE for applicants applying for financial assistance through the FFE is currently limited to enrollment groups consisting of a single tax household (that is, when applying for financial assistance, only applications for which all QIs are on the same tax return are able to enroll in a QHP through the FFE using the DE process).[24] However, DE does accommodate enrollment in QHPs through the FFE for enrollment groups that include multiple tax households as long as all of the applicants are not seeking financial assistance.

If a group of applicants apply for financial assistance through the FFE using DE and the applicants are identified as having multiple tax households, the FFE will relay this information to the applicant and DE Entity, and the DE Entity will review the information with the applicant. The DE Entity should advise the applicants that DE does not support enrollment of multi-tax households when financial assistance is sought. The DE Entity should also advise the applicants that if they want to continue using DE, they must complete separate applications for financial assistance (a separate application for each tax household), or they can complete a non-financial assistance application if they would like to enroll together using DE.

DE Entities must also use an issuer's current subscriber-dependent rules when determining who can be insured under one policy. DE Entity 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 different valid enrollment groups, if desired. The *FFE DE API for Web-Brokers/Issuers Technical Specifications*[25] addresses how to allocate APTC when there are multiple enrollment groups. If a DE Entity offering a classic DE pathway is unable to support multiple enrollment groups, it must make the applicant aware that they can access this functionality at HealthCare.gov, as described in the disclaimers that follow.[26] Note that EDE Entity websites must include functionality that allows QIs to group in any way that is acceptable based on the issuer's current business rules, and EDE Entities are therefore not permitted to display the applicable portion of the disclaimer (see **Section 4.4.1**, **QHP Issuer DE Entities**) required under 45 CFR 156.1230(a)(1)(iv) in lieu of supporting multiple enrollment group functionality.

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

Additionally, due to operational limitations, dental-only enrollment is not permitted via DE. QDP issuers who only offer dental coverage are therefore not permitted to participate in DE at this time.

[24] This same limitation also exists for non-DE enrollment pathways.
[25] See https://zone.cms.gov/document/direct-enrollment-de-documents-and-materials (requires CMSzONE access).
[26] After October 31, 2026, the classic DE pathway will be retired.

However, concurrent enrollment in both a QHP and a QDP is permitted via DE. Applicants who wish to enroll in a QDP via DE may do so after making a QHP selection. DE Entities that offer concurrent QHP and QDP enrollment must note, however, that any elected APTC must first be applied towards the essential health benefits (EHB) portion of the QHP, and then any remaining APTC can only be applied towards any pediatric (i.e., for those applicants under the age of 19) portion of the dental premium.

APTC cannot be applied towards any dental premium applicable to an adult enrollee. The *FFE DE API for Web-Brokers/Issuers Technical Specifications*[27] addresses in greater detail how to allocate APTC. QHP issuer DE Entities that do not offer dental coverage must also provide a disclaimer to applicants, stating that dental coverage is available via HealthCare.gov.[28]

4.4 QHP Display Guidance

QHP issuers and web-brokers that are seeking approval or that have obtained approval to use DE must adhere to the applicable CMS requirements with respect to the display of QHP information. Different regulatory requirements extend to the DE Entity websites depending on whether they are QHP issuer websites or web-broker websites. Details on each follow.

4.4.1 QHP Issuer DE Entities

The QHP issuer DE Entity website:

1. Must, in accordance with 45 CFR 156.1230(a)(1)(ii) and 155.205(b)(1)(i)–(viii), provide applicants the ability to view QHPs offered by the issuer and provide standardized comparative information on each available QHP, to the extent such information is required to be available, and that at a minimum includes:
   a. Premium and cost-sharing information (total and net premium based on APTC and/or CSR).
   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. The results of the enrollee satisfaction survey.
   e. Quality ratings.
   f. Medical loss ratio (MLR) information as reported to the Department of Health & Human Services (HHS).
   g. Transparency of coverage measures reported to the Exchange during certification.
   h. The provider directory made available to the Exchange.
2. Must, in accordance, with 45 CFR 155.221(b)(1), display and market QHPs offered through the Exchange, individual health insurance coverage as defined in 45 CFR 144.103 offered outside the Exchange (including QHPs and non-QHPs other than excepted benefits), and any other products, such as excepted benefits, on at least three separate website pages on its non-Exchange website, except as permitted by 45 CFR 155.221(c). This includes not offering non-QHP health plans (e.g., short-term, limited-duration insurance) or non-QHP ancillary products (e.g., vision or accident insurance) alongside QHPs. QHP issuer DE Entities must also provide

[27] See supra note 25.
[28] 45 CFR 156.1230(a)(1)(iv)

applicants the ability to search for off-Exchange products in a separate section of the website other than the QHP webpages; such products may be marketed and displayed after the QHP selection process has been completed.

3. Should provide filters for searching through plan options on QHP issuer DE Entities' QHP websites, which may include, but are not limited to:
   a. All plans.
   b. Premiums.
   c. Deductibles.
   d. Maximum out-of-pocket cost.
   e. Plan type (e.g., HMO, PPO).
   f. Dental coverage included.
   g. Health Savings Account eligible.
4. Must allow applicants to select and attest to their APTC amount, if applicable, 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 CSR, QHP issuer DE Entities should only display the CSR plan variant that an individual is found eligible for when displaying any Silver QHP, or American Indian/Alaska Native CSR variations, at any metal level, as appropriate.
5. Should ensure that information on its QHP webpages is provided to applicants in plain language and in a manner that is timely and provides effective communication for individuals living with disabilities and provides meaningful access for individuals with limited English proficiency at no cost to applicants.
6. Must, in accordance with 45 CFR 155.221(b)(3), limit marketing of non-QHPs during the Exchange eligibility application (if applicable) and QHP plan selection process in a manner that minimizes the likelihood that consumers will be confused as to which products and plans are available through the Exchange and which products and plans are not, except as permitted by 45 CFR 155.221(c)(1). For example, the QHP issuer DE Entity 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 APTC and CSR apply only to QHPs offered through the FFE, as set forth in 45 CFR 156.1230(a)(1)(iii).

QHP issuer DE Entities must ensure that the premiums charged to an applicant using DE are the same as the amount the FFE would have calculated had the applicant selected a QHP via HealthCare.gov. It is important to note that the QHP issuer DE Entity is responsible for collecting information on the tobacco status of each applicant and should factor that in when calculating each enrollee's premium. Currently, the FFE is only able to support changes in enrollees' tobacco status during open enrollment or an SEP as part of the enrollment XML file provided by issuers to the FFE. QHP issuer DE Entities should refer to the other sections of this manual and the *FFE DE API for Web-Brokers/Issuers Technical Specifications*[29] to ensure that they are correctly rating and applying the correct financial amounts for an enrollee based on their situation (e.g., new vs. existing enrollee making a mid-year change, effective date first of the month vs. mid-month, etc.).

QHP issuer DE Entities must provide an HHS-provided universal disclaimer that informs all applicants of the availability of other QHP products offered through the FFE as set forth in 45 CFR

[29] See supra note 25.

156.1230(a)(1)(iv). QHP issuer DE Entities 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 FFE expects that QHP issuer DE Entities will make the disclaimer 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:[30]

"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 (QHPs) available through HealthCare.gov. To see all available QHP options, go to the Health Insurance Marketplace® website at HealthCare.gov.

Also, you should visit the Health Insurance Marketplace®[31] website at HealthCare.gov if:

1. You want to select a catastrophic health plan. (**This only needs to be included if the QHP issuer does not offer catastrophic plans.**)
2. You want to enroll members of your household in separate QHPs. (**This only needs to be included if the QHP issuer does not allow multiple enrollment groups for its classic DE pathway; note that EDE Entities are required to support multiple enrollment groups.**)[32]
3. You want to enroll members of your household in dental coverage. [The plans offered here do not offer pediatric dental coverage and you want to choose a QHP offered by a different issuer that covers pediatric dental services or a separate dental plan with pediatric coverage.] (**This only needs to be included if the QHP issuer does not offer adult dental coverage or pediatric dental coverage.**)"

The following guidelines apply to the prominent display of the disclaimer:

- The disclaimer must be prominently displayed on both the initial QI landing page and on the landing page displaying QHP options (QHP selection page) that appear before the applicant makes a decision to purchase coverage.
- 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).
- The disclaimer must be viewable without requiring the user to select or click on an additional link.

The disclaimer must adhere to the prominent display guidelines described in **Section 4.4.3**, **Prominent Display Requirements**. QHP issuer DE Entities must prominently display an HHS-provided standardized disclaimer to assist consumers in distinguishing between DE Entity website pages that display QHPs and those that display non-QHPs and for which products APTC and CSRs are available, during a single shopping experience, as set forth in 45 CFR 155.221(b)(2). The disclaimer must read:

"You are now leaving the shopping experience for qualified health and dental plans offered through the Marketplace. You must enroll in a Qualified Health Plan offered through the Marketplace to

[30] The portion of the disclaimer related to pediatric dental coverage, indicated in brackets, is not required, but CMS encourages a QHP issuer that does not offer pediatric dental coverage to display this piece of the disclaimer. The portion of the disclaimer text in bold should not be displayed but rather is intended to indicate when the issuer should display the corresponding disclaimer text.

[31] Health Insurance Marketplace® is a registered service mark of HHS.

[32] After October 31, 2026, the classic DE pathway will be retired.

receive financial assistance like premium tax credits or cost sharing reductions that could reduce your costs (if eligible). You must complete a Marketplace eligibility application to determine if you are eligible for financial assistance or other insurance affordability programs like Medicaid or the Children's Health Insurance Program (CHIP).

Tax credits may be applied to pediatric qualified dental plans offered through the Marketplace. Qualified dental plans are not eligible for cost sharing reductions through the Marketplace." **(References to dental plans only need to be included if the QHP issuer DE Entity offers standalone dental plans.)**

QHP issuer DE Entities must display this disclaimer on their own interstitial website page or on a pop-up window when a consumer navigates away from any website page that markets or displays QHPs offered through the Marketplace (i.e., on-Exchange QHPs) to any website page or tab that markets or displays QHPs offered outside the Marketplace (i.e., off-Exchange QHPs) or non-QHPs. This disclaimer must use the exact language provided by HHS and must adhere to the prominent display guidelines described in **Section 4.4.3**, **Prominent Display Requirements**. The interstitial website page or pop-up window must hyperlink the following text to return the consumer to the website page they were last on:

"Click here to return to the shopping experience for qualified health and dental plans offered through the Marketplace." **(References to QDPs may be omitted if the entity does not offer enrollment in QDPs).**

Alternatively, "Go back," or a similar link or button, could be utilized, provided the website clearly indicates to the consumer that they can return to viewing QHPs and QDPs, if applicable.

Similarly, the interstitial website page or pop-up window must hyperlink the following text to allow the consumer to advance to the page displaying off-Exchange QHPs or non-QHPs:

"Click here to view other options."

Alternatively, "Continue," or a similar link or button, could be utilized, provided the website clearly indicates to the consumer that they can proceed with viewing other, off-Exchange options.

4.4.1.1 Standardized Plan Display Requirements for QHP Issuer DE Entities

For the plan year 2027 OEP, the requirement that QHP issuer DE entities differentially display standardized plan options remains in effect. CMS had planned to eliminate this requirement,[33] along with the definition of "standardized option" at 45 CFR 155.20; all requirements pertaining to standardized plan options at 45 CFR 156.201 (July 19, 2026) (the requirements for FFE and State-based Exchange on the Federal Platform [SBE-FP] QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the differential display of standardized plan options on HealthCare.gov at 45 CFR 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE-FP at 45 CFR 155.220(c)(3)(i)(H) and formerly at 45 CFR 156.265(b)(3)(iv). CMS also planned to cease the annual design and publication of these plans in the applicable Payment Notice rulemaking for each plan year. However, on July 16, 2026, the U.S. District Court for the District of Maryland stayed these provisions of the Notice of Benefit and

[33] 87 FR 27208, 27310–27322

Payment Parameters for 2027 (91 FR 29256) Order, ECF No. 31, *City of Columbus v. Kennedy*, No. 26-2215 (D. Md. July 16, 2026). As a result, these provisions did not go into effect, and the prior regulations governing standardized plan options remain in place for plan year 2027 (See https://www.cms.gov/files/document/plan-year-2027-standardized-plan-option-plan-designs.pdf).

QHP issuer DE Entities must therefore continue to differentially display standardized plan options for plan year 2027.

4.4.2 Web-Broker DE Entities

Web-broker DE Entity websites must—in accordance with 45 CFR 155.220(c)(3)(i)(A)(*1*)–(*6*)—disclose and display all QHP information provided by the Exchange or directly by QHP issuers, consistent with the requirements of 45 CFR 155.205(c), for all QHPs, including QDPs,[34] offered through the Exchange.

The standardized comparative information on each available QHP that must be displayed includes the following minimum information:

1. Premium and cost-sharing information (total and net premium based on APTC and CSR)
2. Summary of benefits and coverage
3. Identification of whether the QHP is a Bronze, Silver, Gold, or Platinum level plan, or a catastrophic plan
4. The results of the enrollee satisfaction survey
5. Quality ratings
6. The provider directory made available to the Exchange

In accordance with 45 CFR 155.220(c)(3)(i)(A), if a web-broker DE Entity website does not support enrollment for a QHP, it must prominently display the following standardized Enrollment Support Disclaimer for the specific QHP:

"[Name of Company] does not support enrollment in this Qualified Health Plan at this time. To enroll in this Qualified Health Plan, visit the Health Insurance Marketplace® website at HealthCare.gov."

The mandatory standardized Enrollment Support Disclaimer must:

- Be prominently displayed on any website page where plan information for QHPs is displayed if the web-broker does not support enrollment in any such QHPs, so it is noticeable to the QI or A/B assisting the QI.
- Be provided where the enrollment button (or other similar mechanism) would otherwise appear for a particular QHP, although we will consider a web-broker website in compliance if a visual cue is displayed where the enrollment button (or other similar mechanism) would otherwise appear for a particular QHP if the visual cue provides clear direction to the standardized disclaimer text on the same website page or otherwise displays the standardized disclaimer text (e.g., in a pop-up bubble that appears while hovering over the visual cue on the website).
- Use the exact language provided by HHS.

[34] See supra note 25. CMS expects all web-brokers to follow the same requirements for QDPs as for QHPs, including displaying on their websites all applicable QDPs offered through the Exchange and all available information specific to each QDP. However, because it is not possible to enroll in QDPs through DE unless also enrolling in medical QHPs (see **Section 4.3**, **Enrollment Groups**), web-brokers may modify their QHP displays accordingly (e.g., display QDPs after medical QHPs to ensure a consumer has first selected a medical QHP).

- Include an operational link to the Health Insurance Marketplace® website (HealthCare.gov).
- Adhere to the prominent display guidelines described in **Section 4.4.3**, **Prominent Display Requirements**.

The web-broker DE Entity website must:

1. Adhere to the website display standards specified in 45 CFR 155.220(c)(3)(i)(A)(*1*)–(*6*). Web-broker DE Entities must disclose and display all QHP information provided by the FFE or directly by QHP or QDP issuers.
2. Provide QIs and A/Bs assisting QIs the ability to view all QHPs offered through the Exchange, in accordance with 45 CFR 155.220(c)(3)(i)(B). Web-broker DE Entities must display all QHPs available through an Exchange, irrespective of compensation or appointment arrangements.
3. Provide no financial incentives, such as rebates or giveaways, in accordance with 45 CFR 155.220(c)(3)(i)(C).
4. Display all QHP data provided by the Exchange, in accordance with 45 CFR 155.220(c)(3)(i)(D). CMS makes detailed QHP data available to web-brokers registered with the FFE through the release of the QHP Landscape Files[35] and the Health Insurance Exchange Public Use Files (PUFs).[36] CMS recommends that web-brokers registered with the FFE use these files, in addition to information a web-broker registered with the FFE obtains through its relationships with QHP issuers, to display required QHP standardized comparative information. Alternatively, web-brokers can obtain a real-time feed of QHP information using the Marketplace API. If web-brokers are interested in integrating with the Marketplace API, the API key request form and related documentation can be found at https://developer.cms.gov/marketplace-api/.
5. Provide QIs with the ability to withdraw at any time from the process and instead use the Exchange website, in accordance with 45 CFR 155.220(c)(3)(i)(F).
6. Prominently display information provided by the Exchange pertaining to a consumer's eligibility for APTC or CSR and allow the consumer to select an amount for APTC, if applicable, and make related attestations, in accordance with 45 CFR 155.220(c)(3)(i)(I) and (c)(3)(i)(J).
7. Not display QHP advertisements or recommendations or otherwise provide favored or preferred placement in the display of QHPs, based on compensation the agent, broker, or web-broker receives from QHP issuers, in accordance with 45 CFR 155.220(c)(3)(i)(K).
8. Prominently display a clear explanation of the rationale for QHP recommendations and the methodology for its default display of QHPs, in accordance with 45 CFR 155.220(c)(3)(i)(L).
9. Display and market QHPs offered through the Exchange, individual health insurance coverage as defined in 45 CFR 144.103 offered outside the Exchange (including QHPs and non-QHPs other than excepted benefits), and any other products, such as excepted benefits, on at least three separate website pages on its website, in accordance with 45 CFR 155.221(b)(1), except as permitted by 45 CFR 155.221(c). This includes not offering non-QHP health plans (e.g., short-term, limited-duration insurance) or non-QHP ancillary products (e.g., vision or accident insurance) alongside QHPs. Web-broker DE Entities must also provide applicants the ability to

[35] Available at https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/.
[36] Available at http://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html.

search for off-Exchange products in a separate section of the website other than the QHP webpages; such products may be marketed and displayed after the QHP selection process has been completed.

10. Limit marketing of non-QHPs during the Exchange eligibility application and QHP plan selection process in a manner that minimizes the likelihood that consumers will be confused as to which products and plans are available through the Exchange and which products and plans are not, in accordance with 45 CFR 155.221(b)(3), except as permitted by 45 CFR 155.221(c)(1). For example, the web-broker DE Entity website must clearly distinguish between QHPs for which the QI is eligible and other non-QHPs that the web-broker DE Entity may offer and indicate that APTC and CSR apply only to QHPs offered through the FFE.

Web-broker DE Entity websites must also prominently display the General non-FFE Disclaimer in accordance with 45 CFR 155.220(c)(3)(i)(G). Please note that this disclaimer was revised by CMS in October 2016[37] to also address situations where web-brokers offer consumers assistance with other coverage options (e.g., off-Exchange plans). This disclaimer has been further revised to align with updates to 45 CFR 155.220(c)(3)(i)(A).[38] The disclaimer must read:[39]

"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 support enrollment in all Qualified Health Plans (QHPs) being offered in your state through the Health Insurance Marketplace® website. For enrollment support in all available QHP 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. (**This only needs to be included if the web-broker does not offer catastrophic plans.)**
- You want to enroll members of your household in separate QHPs. (**This only needs to be included if the web-broker does not allow multiple enrollment groups for its classic DE pathway; note that EDE Entities are required to support multiple enrollment groups.)**[40]
- You want to enroll members of your household in dental coverage. [The plans offered here do not offer pediatric dental coverage and you want to choose a QHP offered by a different issuer that covers pediatric dental services or a separate dental plan with pediatric coverage.] (**This only needs to be included if the web-broker does not offer assistance with enrollment in adult dental coverage or pediatric dental coverage.**)

[37] See https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Guidance-Web-brokers-FFMs.pdf.

[38] See 87 FR 27208 at 27258, 86 FR 24140 at 24208, and *Web-broker Website Display Bulletin* (August 17, 2021) available at https://www.cms.gov/files/document/web-broker-website-display-bulletinfinal08172021.pdf.

[39] The portion of the disclaimer related to pediatric dental coverage, indicated in brackets, is not required; CMS encourages a web-broker DE Entity's website that does not include plans that offer pediatric dental coverage to display this piece of the disclaimer. The portion of the disclaimer text in bold should not be displayed but rather is intended to indicate when the web-broker should display the corresponding disclaimer text.

[40] After October 31, 2026, the classic DE pathway will be retired.

[Name of web-broker's website] offers the opportunity to enroll in either QHPs or off-Marketplace coverage. Please visit HealthCare.gov for information on the benefits of enrolling in a QHP. Off-Marketplace coverage is not eligible for the cost savings offered for coverage through the Marketplaces. (**This final paragraph must be displayed if the web-broker offers consumers assistance with off-Marketplace coverage options.**)"

The web-broker DE Entity must observe the following requirements for displaying the General non-FFE Disclaimer:

- The Disclaimer must be prominently displayed on both the initial QI landing page and on the landing page displaying QHP options that appear 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).
- The Disclaimer must adhere to the prominent display guidelines described in **Section 4.4.3**, **Prominent Display Requirements**.

Web-broker DE Entities must prominently display an HHS-provided standardized disclaimer to assist consumers in distinguishing between DE Entity website pages that display QHPs and those that display non-QHPs and for which products APTC and CSRs are available, during a single shopping experience, as set forth in 45 CFR 155.221(b)(2). Web-broker DE Entities must adopt the same disclaimer text and follow the same guidance for display that applies to QHP issuer DE Entities. Refer to **Section 4.4.1**, **QHP Issuer DE Entities**, for details on the disclaimer text and display requirements.

CMS expects that web-broker DE Entities prominently display language explaining to QIs that the web-broker has entered into an Agreement(s) with the FFE and has agreed to conform to the website display and security standards in 45 CFR 155.220(c)(3) and 155.260. In addition, consistent with 45 CFR 155.220(j)(2)(i), web-brokers and other A/Bs may not use "Marketplace" or "Exchange" or other words in the name of their businesses or websites if doing so could mislead a QI into believing they are visiting HealthCare.gov. Consistent with the obligation to provide QIs with correct information under 45 CFR 155.220(j)(2)(i), web-brokers registered with the FFE must also advise QIs that APTC and CSR apply only to QHPs offered through the FFE.

CMS expects that web-broker DE Entities will clearly distinguish between QHPs for which the QI is eligible and QHPs for which the QI may not be eligible. For example, the display of child-only plans should be limited to QIs eligible for such coverage (e.g., individuals under the age of 21) to avoid confusion.

45 CFR 155.220(c)(3)(i)(L) prohibits web-broker DE Entity websites from displaying QHP advertisements or recommendations or otherwise providing favored or preferred placement in the display of QHPs, based on compensation an agent, broker, or web-broker receives from QHP issuers. Web-broker DE Entities may offer filtering capabilities or decision support tools that the QI or A/B assisting the QI can use to navigate or refine the display of QHPs consistent with CMS guidance.[41] If a web-broker DE Entity offers the QI or A/B assisting the QI the use of additional sort functionality to alter the order of the QHPs listed, regardless of how the QI or A/B assisting the QI chooses to sort the

[41] See *Web-broker Website Display Bulletin* (August 17, 2021) available at https://www.cms.gov/files/document/web-broker-website-display-bulletinfinal08172021.pdf.

QHPs (e.g., lowest monthly premium, lowest deductible), the web-broker DE Entity website must still provide QIs or A/Bs assisting QIs the ability to view all QHPs offered through the FFE in compliance with 45 CFR 155.220(c)(3)(i)(B). A web-broker DE Entity may also allow the QI or A/B assisting the QI to apply filters to the QHPs listed (e.g., metal level, provider network, issuer). In this case, web-broker DE Entities must ensure that if the QI or A/B assisting the QI were to select all of the available options for a certain filter (e.g., all available metal levels), the total number of plans displayed would remain consistent with the number of QHPs offered through the FFE that satisfy the selection criteria. In addition, if a QI or A/B assisting a QI selects a certain filter (e.g., Bronze metal level), the web-broker DE Entity website must display all QHPs offered through the FFE that satisfy that filter's description.

CMS expects that the web-broker DE Entity will display language explaining to the QI the specific source and nature of web-broker compensation and that compensation does not affect the display of QHP options or premiums charged. Web-broker DE Entities must 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 or a QHP).[42] Once a QI has completed the QHP selection and enrollment, the web-broker DE Entity may offer the QI or A/B assisting the QI the ability to search for additional products or services if desired. Such offers must be made in a section of the web-broker DE Entity website that is separate from the QHP display and plan selection.[43]

CMS generally expects that QIs are not charged a separate transaction or service fee for shopping or enrolling in a QHP through a web-broker DE Entity website. CMS recognizes that web-broker DE Entities may have invested significant resources to develop special software to assist QIs with selection and enrollment in QHPs offered through the FFE, 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 FFE, it may be appropriate to allow for the collection of an additional fee. However, any practice of collecting such fees from QIs for providing assistance with QHP selection and enrollment through the FFE 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 QIs for selecting and submitting QHP applications offered through the FFE through a non-FFE website should provide a disclaimer to QIs that 1) clearly discloses the amount and reason for the fee and 2) informs the QI that they can apply through the FFE website (HealthCare.gov) at no cost.

A web-broker DE Entity can allow other A/Bs to use its website to enroll QIs, employers, and employees in a QHP through the FFE by entering into a contractual or other arrangement.[44] The A/B accessing the web-broker DE Entity website pursuant to the arrangement should be listed as the agent of record on the enrollment. The web-broker DE Entity must verify that any other A/B accessing its website is licensed by the applicable state(s) and completed FFE registration for the current plan year (including completion of applicable training and execution of applicable Agreements with the FFE).[45]

[42] 45 CFR 155.220(c)(3)(i)(K) and 155.221(b)(3)
[43] 45 CFR 155.221(b)(1)
[44] 45 CFR 155.220(c)(4)
[45] 45 CFR 155.220(c)(4)(i)(B)

A web-broker DE Entity that allows another A/B registered with the FFE to use the web-broker's website must, as mandated by 45 CFR 155.220(c)(4)(i)(C), ensure that the web-broker's name and National Producer Number (NPN) are prominently displayed:

- On every page of the website, even if the A/B registered with the FFE accessing the web-broker DE Entity website is able to customize the appearance of the website.
- On the cover or first page of all written materials containing QHP information that can be printed directly from the website. This includes all files containing QHP information that can be downloaded directly from or viewed directly on the website. Documents linked to or from the site that a separate entity maintains are not included in this definition.

CMS considers this information to be prominently displayed if it is displayed consistent with the guidelines outlined in **Section 4.4.3**, **Prominent Display Requirements**.

The web-broker DE Entity must terminate an A/B's access to its website if CMS determines that the A/B is in violation of any applicable FFE requirements.[46] In addition, web-broker DE Entities must report to HHS and applicable state regulators any potential material breach of the A/B FFE requirements, including the privacy and security standards under 45 CFR 155.260(b) by the A/B accessing its website, should the web-broker become aware of any such potential breach.[47]

4.4.2.1 Standardized Plan Display Requirements for Web-Broker DE Entities

For the plan year 2027 OEP, the requirement that web-broker DE Entities differentially display standardized plan options remains in effect. CMS had planned to eliminate this requirement;[48] however, on July 16, 2026, the U.S. District Court for the District of Maryland stayed these provisions of the Notice of Benefit and Payment Parameters for 2027 (91 FR 29256) Order, ECF No. 31, *City of Columbus v. Kennedy*, No. 26-2215 (D. Md. July 16, 2026). As a result, these provisions did not go into effect, and the prior regulations governing standardized plan options remain in place for plan year 2027 (See https://www.cms.gov/files/document/plan-year-2027-standardized-plan-option-plan-designs.pdf).

Web-broker DE Entities must therefore continue to differentially display standardized plan options for plan year 2027. Refer to **Section 4.4.1.1**, **Standardized Plan Display Requirements for QHP Issuer DE Entities**, for additional information about this requirement.

4.4.3 Prominent Display Requirements

Section 4.4, **QHP Display Guidance**, requires DE Entity websites to prominently display certain content (e.g., disclaimer language, graphics or iconography, and help text) on their non-Exchange websites pursuant to the website display regulations in 45 CFR 156.1230, 45 CFR 155.220, 45 CFR 155.221, and 45 CFR 156.265.

The following guidelines apply to the prominent display of such content:

- Text must be written in a font size no smaller than the majority of the text on the webpage.
- Text must be displayed in the same non-English language as any language(s) the QHP issuer maintains screens for on its website.

[46] 45 CFR 155.220(c)(4)(i)(D)
[47] 45 CFR 155.220(c)(4)(i)(E)
[48] 87 FR 27208, 27310–27322

- Content must be noticeable in the context of the website (e.g., use a font or graphic/iconography color that contrasts with the background of the webpage).

A DE Entity website may change the font color, size, or graphic context of the information to ensure that it is noticeable to the QI in the context of its website or the other written material.

4.5 Mandatory Display Language for Consumers that Attest to a Health Reimbursement Arrangement Offer

DE Entities assisting QIs with enrollment must be aware that some QIs may need to attest to a Health Reimbursement Arrangement (HRA) offer when completing the eligibility application. The Fetch Eligibility API and Standalone Eligibility Services (SES) API responses will indicate when a QI attests to an HRA offer and will indicate if the FFE has determined affordability for the offer. The HRA offer, and whether the offer is accepted, and the HRA's affordability may impact an applicant's eligibility for a QHP or a QI's eligibility for APTC. Accordingly, DE Entities are required to display specific language to QIs with an HRA offer, depending on the type and affordability of the HRA offered to the QI. The *FFE DE API for Web-Brokers/Issuers Technical Specifications* available on CMSzONE at https://zone.cms.gov/document/direct-enrollment-de-documents-and-materials outlines the required language that DE Entities must display for various scenarios.

4.6 Mandatory Attestations

DE Entities using their own websites, and any A/Bs using a DE Entity website, to enroll individuals into QHPs in a manner considered to be through the FFE are required to collect attestations for those households receiving APTC as set forth in 45 CFR 156.1230(a)(1)(v) (applicable to QHP issuers' websites) and 45 CFR 155.220(c)(3)(i)(J) (applicable to web-brokers' websites and A/B users of a web-broker's website). The FFE will identify the expected tax filers for the plan year from each tax household and the DE Entity, or the A/B using the DE Entity's website, must collect and retain an attestation from each tax filer. For each household identified as needing an attestation, the following language should be used:

- Advance payments of the premium tax credit (APTC) attestation.
- Review the statements below for [tax filer(s) – household 1] (in a DE Consumer flow, this attestation should be displayed to the consumer in the DE Entity's User Interface (UI), whereas in an A/B flow, the A/B should verbally review the attestation with the consumer).
- I understand that because APTC will be paid on my behalf to reduce the cost of health insurance coverage for myself and/or my dependents.
- I must file a Federal income tax return in [plan year +1] for the tax year [plan year].
- If I am married at the end of [plan 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 [plan year] Federal income tax return.
- I will claim a personal exemption deduction on my [plan 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 APTC for which I am the applicable tax filer.

- If any of the above changes, I understand that it may impact my ability to get the premium tax credit (PTC).
- I also understand that when I file my [plan year] Federal income tax return, the Internal Revenue Service (IRS) will compare eligibility information for [plan year] to what I reported on my Marketplace application, including the household income on my tax return with the household income on my application. I understand changes in eligibility information could affect eligibility for the PTC. For example, 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 PTC 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 FFE, DE Entities indicate the amount of APTC the household has selected and confirm that the tax filer has attested to the language above.

Additionally, the DE Entity, or the A/B using the DE Entity's website, must maintain attestations for a minimum of 10 years.[49]

[49] 45 CFR 155.220(c)(3)(i)(E) and 156.705(c)

5. Special Enrollment Periods (Applicable to the Individual Market FFE, QHPs/QDPs)

5.1 Introduction

Pursuant to 45 CFR 155.410(a)(2), and 45 CFR 155.420, Special Enrollment Periods (SEPs) allow a qualified individual (QI) or enrollee who experiences certain qualifying events to enroll in, or change enrollment in, a Qualified Health Plan (QHP) or Qualified Dental Plan (QDP) through the Exchange outside of the annual Open Enrollment Periods (OEPs).

Exchanges must adhere to the parameters for SEPs defined at 45 CFR 155.420.

This section provides an overview of events that trigger SEPs and details about how the Federally-facilitated Exchange (FFE) administers them. Information on the applicability of binder payments rules is available in **Section 6.1**, **Introduction**.

5.2 SEP Pre-enrollment Verification

The FFE generally conducts pre-enrollment verification of newly enrolling individuals' SEP eligibility. SEP verification is intended to promote program integrity and continuous coverage, protect the risk pool, and stabilize rates. The preamble of the 2017 Market Stabilization Rule provided State-based Exchanges (SBEs) with flexibility to determine whether and how to implement SEP pre-enrollment verification. [50]

The 2023 Notice of Benefit and Payment Parameters scaled back pre-enrollment SEP verification in the FFE to include only the SEP for loss of minimum essential coverage (MEC)—the SEP type that comprises the majority of all SEP enrollments through the FFE.[51] It also stated that SBEs maintain flexibility to verify eligibility for any SEP types and that Exchanges may provide an exception for SEP verification for special circumstances that impact consumers or the Exchange, such as natural disasters or a public health emergency. [52]

SEP verification does not impact the individual's Exchange-generated effective date, which is typically determined by the SEP triggering event and the date the individual selects a QHP (see

[50] Rule Document CMS-2017-0021-4021

[51] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 (87 FR 27208, 27277) (May 6, 2022)

[52] On June 25, 2025, the Department of Health and Human Services (HHS) published the Marketplace Integrity and Affordability Final Rule (90 FR 27074), which finalized amendments to 45 CFR 155.420(g) to enable HHS to reinstate pre-enrollment verification of eligibility of applicants for all SEPs. The rule stated that the requirement could be satisfied if an Exchange verifies eligibility each plan year for the number of individuals newly enrolling in Exchange coverage through SEPs that equals at least 75 percent of all individuals enrolled through SEPs in the previous year. This provision was scheduled to go into effect on August 25, 2025, and to sunset of December 31, 2026. However, pursuant to orders of the Federal district court for the District of Maryland in *City of Columbus v. Kennedy*, No. 25-cv-2114-BAH (D. Md.) (*City of Columbus II*), implementation of this provision did not go into effect.
Additionally, on May 25, 2026, HHS published the Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program Final Rule (91 FR 29526) reproposing the same policy, effective for PY 2027, except without a sunset date. This policy has been stayed pursuant to an order of the Federal district court for the District of Maryland in *City of Columbus v. Kennedy*, No. 1:26-cv-02215 (D. Md.) (*City of Columbus III*.). Therefore, as of the date of publication of this Enrollment Manual, the SEP verification policy established in 2023 Notice of Benefit and Payment Parameters remains in effect.

Section 5.6, **SEP Triggering Events and Coverage Effective Dates**, for more information on SEP triggering events and coverage effective dates). However, pursuant to 45 CFR 155.400(e)(1)(iii), as with other retroactive effective dates, if a consumer only pays a premium for one month of coverage, only prospective coverage should be effectuated, in accordance with regular effective dates.

Individuals subject to SEP verification have their enrollment pended until the FFE completes verification of SEP eligibility either through automated electronic means or based on documentation that the individual submits. The requirement to verify SEP eligibility is referred to as an SEP verification issue (SVI).[53] If the FFE cannot automatically verify an individual's SEP eligibility, then the individual must submit documentation within 30 calendar days of plan selection in order to verify eligibility. Once an individual's SEP eligibility has been verified, the FFE will release their enrollment information to the relevant issuer. SEP verification only applies to the loss of MEC SEP type.

5.3 Plan Category Limitations for SEPs

Under some SEPs, consumers may be limited in their ability to change plans during the plan year. This plan category limitations (PCL) policy is codified in regulation at 45 CFR 155.420(a)(3) and (4). It applies to enrollees in Exchange coverage, but not to those enrolled in individual market coverage off-Exchange. The FFE implemented PCL in February 2019. Direct Enrollment (DE) partners that process enrollments through SEPs must implement functionality to ensure enrollees subject to PCL can only see plans for which they are eligible, and those requirements can be found in the DE Application Programming Interface (API) specifications at https://zone.cms.gov/document/direct-enrollment-de-documents-and-materials.

5.4 PCL Background

Health plans sold in the Exchange are divided into categories: Bronze, Silver, Gold, and Platinum. They range from Bronze plans, which have lower premiums and higher out-of-pocket costs, to Platinum plans, which have higher premiums and lower out-of-pocket costs. Catastrophic plans, which have lower monthly premiums and higher out-of-pocket costs, and which are not eligible for premium tax credit (PTC), may also be available to people under age 30 and people who qualify for hardship or affordability exemptions.

Under PCL, enrollees who qualify for most SEP types and want to change plans during the year will have a limited number of plan categories to choose from. This means if an enrollee wants to change plans during an SEP for which they qualify, they may need to select a new plan within the same plan category as their current plan or wait until the next OEP if they want to change to a plan in a different category. Exceptions to this rule include:

- If an enrollee or their dependent(s) becomes newly eligible for cost-sharing reduction (CSR) and is not already enrolled in a Silver plan, that enrollee and their dependents can choose a plan in the Silver category to use their CSR.
- If an enrollee or their dependent(s) becomes newly ineligible for CSR and is enrolled in a Silver-level QHP, that enrollee and their dependents can change to a QHP one metal level higher or lower, if they want to change their QHP enrollment.

[53] https://www.cms.gov/marketplace/in-person-assisters/technical-resources/special-enrollment-periods

- No later than January 2024, Exchanges must allow an enrollee or their dependent(s) who becomes newly ineligible for advance payments of the PTC (APTC) to change to a plan of any category.
- If an enrollee gains a dependent due to marriage, birth, adoption, foster care, or court order or has a dependent who qualifies for an SEP for which the enrollee does not also qualify, they can add the new dependent to their current plan or, if the QHP's business rules do not allow the dependent to enroll, the enrollee and their dependents can change to another QHP within the same level of coverage (or one metal level higher or lower, if no such QHP is available). Alternatively, they can enroll the new dependent in a plan of any plan category. To enroll the new dependent in a plan of any plan category, the enrollee must create a separate enrollment group for their dependent before proceeding to Plan Compare to view all plans available to the new dependent.
- If a QI who is not an enrollee qualifies for an SEP and has one or more dependents who are enrollees who do not also qualify for an SEP, the newly enrolling QI can be added to the dependent's current QHP; or, if the QHP's business rules do not allow the QI to enroll in the dependent's current QHP, to enroll with the dependent in another QHP within the same level of coverage (or one metal level higher or lower, if no such QHP is available). Alternatively, the QI can enroll in a separate QHP.

Finally, certain SEPs are exempted from PCL and permit qualifying enrollees to change to a plan of any plan category. For more details about PCL rules by SEP type, see **Exhibit 15**.

5.5 Availability and Length of SEPs

The FFE determines whether an individual is eligible for an SEP based on a qualifying event described in 45 CFR 155.420(d). Pursuant to 45 CFR 155.420(c), unless otherwise stated, SEPs in the FFE and other Exchange individual markets generally last 60 days from the date of the triggering event. Exceptions to the 60-day availability period include:

- Certain SEPs for which the FFE may define the length of the SEP based on the circumstances, such as SEPs related to enrollment errors, exceptional circumstances, and misrepresentation.[54] The SEPs for these situations may last less than 60 days, depending on the specific situation, but will not last for longer than 60 days.
- Cases in which a QI did not receive timely notice of a triggering event and was otherwise reasonably unaware that a triggering event occurred, in which case the Exchange will provide the QI with 60 days from the date they knew, or reasonably should have known of the triggering event to enroll in a QHP.
- Exchanges have the option to provide QIs or their dependent(s) losing Medicaid or Children's Health Insurance Program (CHIP) coverage within 60 days before and 90 days after their loss of Medicaid or CHIP coverage to report a qualifying event and select a QHP. SBEs that operate their own eligibility and enrollment platforms have additional flexibility to provide a longer SEP window for Medicaid or CHIP coverage losses, up to the number of days provided for the applicable Medicaid or CHIP reconsideration period.

[54] See 45 CFR 155.420(c)(3). In the case of QIs/enrollees eligible for an SEP based on criteria in 45 CFR 155.420(d)(4), (d)(5), or (d)(9), the Exchange 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."

In addition, the FFE offers advanced availability of the SEP for loss of MEC for QIs or their dependents, so these individuals have up to 60 days before and up to 60 days after the loss of coverage to report a qualifying event and select a QHP. The FFE also offers advanced availability of the SEP for QIs or their dependents who newly gain access to an individual coverage Health Reimbursement Arrangement (ICHRA) or are newly provided a qualified small employer HRA (QSEHRA). Individuals eligible for this ICHRA/QSEHRA SEP have 60 days before the triggering event to select a QHP, unless the ICHRA or QSEHRA was not required to provide the notice setting forth its terms to such enrollee at least 90 days before the beginning of the plan year, in which case the QI or their dependent has 60 days before or after the triggering event to select a QHP. A QI or their dependent who has elected COBRA continuation coverage (including state "mini-COBRA" coverage) with employer contribution or government subsidies, and the contribution or subsidies completely cease, also can enroll in a QHP up to 60 days before the last day of the period for which COBRA continuation coverage is paid for or subsidized, in whole or in part, by an employer or government entity.

Exchanges have the option to offer advanced availability to QIs and enrollees who qualify for an SEP due to a permanent move, become newly eligible for PTCs as a result of a move or increase in income above 100 percent Federal Poverty Level (FPL) after having been ineligible for Medicaid because they were living in a non-Medicaid expansion state, or become newly eligible for QHP coverage due to a change in immigration status or a release from incarceration; however, the FFE does not currently offer advanced availability for these SEPs.

5.6 SEP Triggering Events and Coverage Effective Dates

Individuals may qualify for an SEP under 45 CFR 155.420(d) based on certain triggering events. Certain SEPs are available to all QIs who experience a triggering event, while others are only available to current enrollees, or individuals who previously had MEC. Most triggering events apply to all individual (FFE and SBE) Exchanges; however, in some cases, triggering events are at the option of the Exchange, and therefore may not be operationalized in every Exchange. See **Exhibit 15** for a description of the applicability of each SEP.

In some circumstances, an individual may not be aware that an SEP triggering event has occurred until after it happens. Pursuant to 45 CFR 155.420(c)(5), the Exchange will provide such individuals 60 days from the date they knew, or reasonably should have known, of the triggering event to enroll in a QHP. In order to take advantage of this provision, the individual must have been reasonably unaware that a triggering event occurred.

Coverage effective dates for individuals who enroll through an SEP are established in 45 CFR 155.420(b) and apply to SEPs offered in individual Exchanges.

The FFE has established a deadline of March 31 each year for submission of new requests for an SEP that would enable consumers to enroll in a QHP with effective dates for the prior plan year. After March 31 of each year, new FFE SEP requests eligible for a retroactive effective date will be given a coverage effective date no earlier than January 1 of the current year, with the exception of the SEPs described at 45 CFR 155.420(d)(4), (d)(9), and (d)(11). For example, if a consumer submits an SEP request on April 7 that would otherwise entitle the consumer to enroll in prior-year coverage, the applicant will be granted an effective date of January 1. This guidance does not apply to eligibility appeals and does not impact a consumer's right to request an appeal of their eligibility determination in accordance with 45 CFR 155.505(b).

5.6.1 Coverage Effective Dates

Pursuant to 45 CFR 155.420(b)(2)(i), for a QI who gains a dependent or becomes a dependent through birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order, an Exchange must offer coverage **retroactive** to the date of birth (DOB), adoption, placement for adoption or in foster care, or the date of the child support or other court order. QIs may also elect a later coverage effective date (the first of the month following plan selection in accordance with paragraph (b)(3)(i)) by calling the Marketplace Call Center.

Pursuant to 45 CFR 155.420(b)(2)(iii), for certain SEP triggering events, an Exchange may provide for a coverage effective date that is appropriate based on the circumstances of the SEP. For example, when individuals or enrollees have experienced an Exchange error that impacts their enrollment or non-enrollment in coverage (per 45 CFR 155.420(d)(4)), they will be given the option for a retroactive coverage effective date back to their initially intended coverage effective date, absent the error.

45 CFR 155.420(b)(2)(iv) provides that certain SEPs offer **accelerated coverage effective dates**, which is the date of the first day of the month following the triggering event, if the plan selection is made on or before the day of the triggering event, regardless of whether plan selection takes place in the first or second half of the month. If plan selection is made after the date of the triggering event, the Exchange has the option to provide regular effective dates per 45 CFR 155.420(b)(1) and (3)(i), or to provide that coverage take effect the first of the month following plan selection (see **Exhibit 15** for more detail on which rule applies in the FFE based on triggering event). For example, individuals or enrollees who qualify for an SEP due to a loss of MEC (per 45 CFR 155.420(d)(1) or (d)(6)(iii)) or who have elected COBRA continuation coverage to which an employer or government entity is contributing and the contributions completely cease (per 45 CFR 155.420(d)(15)) may be eligible to enroll in coverage with an accelerated coverage effective date. 45 CFR 155.420(b)(2)(vi) applies to the SEP for individuals who newly gain access to an ICHRA or to a QSEHRA, and provides for a similar accelerated coverage effective date rule to what is provided at (b)(2)(iv), but specifies that if the plan selection is made before the day of the triggering event, coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, coverage is effective on the first day of the month following plan selection. Unless otherwise noted, consistent with 45 CFR 155.420(b)(3)(i), all SEPs within the FFE follow **accelerated coverage effective dates** for enrollment so that QHP coverage is effective on the first of the month immediately following plan selection.

In addition to the accelerated coverage effective date rules at 45 CFR 155.420(b)(2)(iv), Exchanges also have the option to offer earlier coverage effective dates for consumers attesting to a future loss of MEC. Specifically, if an Exchange elects this option, for future coverage losses at 45 CFR 155.420(d)(1), (d)(6)(iii), or (d)(15), if a consumer selects a plan on or before the last day of the month preceding their loss of coverage, an Exchange must ensure that the coverage effective date is the first of the month in which the triggering event occurs.

Pursuant to 45 CFR 155.420(b)(5), in circumstances in which a QI was reasonably unaware that an SEP triggering event occurred (see **Section 5.6**, **SEP Triggering Events and Coverage Effective Dates**), the Exchange will provide the individual 60 days from the date they knew, or reasonably should have known, about the SEP triggering event to enroll in a QHP and will provide them with the earliest effective date that would have otherwise been available to them.

Exhibit 15 summarizes the six categories of SEP triggering events from 45 CFR 155.420(d) as well as coverage effective dates for each SEP. It also includes information on:

- Whether the SEP is subject to pre-enrollment verification (SEP-V).
- Whether the SEP is subject to PCL, and if so, what the specific limitation for the existing enrollee is.
- Whether the SEP is at the option of the Exchange.
- How QIs can access the SEP (i.e., through the FFE application or through the Marketplace Call Center).
- SEP enrollment codes.

Exhibit 15: SEP Triggering Events and Coverage Effective Dates Summary

SEP Category	Regulatory Authority Under 45 CFR 155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Loss of qualifying health coverage	(d)(1)(i-iv) – Loss of MEC *New Enrollees Subject to SEP-V **(d)(1)(ii) – The end of the plan year for any non-calendar year group health coverage ***Existing enrollees will generally be limited to plan options within their current plan category.	A QI or their dependent loses MEC, including but not limited to Medicaid, CHIP, or qualifying employer sponsored coverage. For purposes of qualifying for this SEP, this includes: • The end of the plan year for any non-calendar year group health plan or individual health insurance coverage, including a non-calendar year ICHRA or a QSEHRA. • Losing pregnancy-related coverage described under Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (SSA) or access to healthcare services through coverage provided to a pregnant woman's unborn child. • Losing medically needy coverage described under Section 1902(a)(10)(C) of the SSA only once per calendar year. **NOTE**: This does not include QIs who have lost their coverage due to nonpayment of premiums, voluntary termination, or as a result of an act of fraud by the QI (or other acts that would qualify for rescission) (per 45 CFR 155.420(e)). **Coverage Effective Dates**: • Plan selection after Loss of MEC: First of the month after plan selection • Plan selection prior to or on the date of the Loss of MEC: First of the month following the loss of MEC Exception: if plan selection occurs on or before last day of the month before Loss of MEC: First of the month in which the loss of MEC occurs **NOTE**: This is at the option of an Exchange and only for consumers reporting a future loss of MEC.	07	Application

SEP Category	Regulatory Authority Under 45 CFR 155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Loss of qualifying health coverage through an employer sponsored plan (continued)	(d)(6)(iii) – Become newly eligible for APTC due to changes to current employer–sponsored coverage **Existing enrollees will generally be limited to plan options within their current plan category.	A QI or their dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based 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). **Coverage Effective Dates**: • Plan selection after loss of MEC: First of the month after plan selection • Plan selection prior to or on the date of the loss of MEC: First of the month following the loss of MEC Exception: if plan selection occurs on or before last day of the month before Loss of MEC: First of the month in which loss of MEC occurs **NOTE**: This is at the option of an Exchange and only for consumers reporting a future loss of MEC. This option is not available in the FFE.	07	Application
Loss of qualifying health coverage COBRA assistance (continued)	(d)(15) – Complete cessation of employer contributions or government subsidies to COBRA continuation coverage	A QI or their dependent who has elected COBRA continuation coverage (including state "mini-COBRA" coverage) with employer contributions or government subsidies, and the contributions or subsidies completely cease. The triggering event is the last day of the period for which COBRA continuation coverage is paid for or subsidized, in whole or in part, by an employer or government entity. **NOTE**: Because eligibility for this SEP is based on the loss of contributions or subsidies rather than the loss of coverage itself, it is not necessary for an enrollee to end their coverage before enrolling through this SEP. **Coverage Effective Dates**: • Plan selection after loss of subsidies: First of the month after plan selection • Plan selection prior to or on the date of the loss of subsidies: First of the month following the loss of contributions or subsidies Exception: if plan selection occurs on or before last day of the month before Loss of MEC: First of the month in which loss of MEC occurs **NOTE**: This is at the option of an Exchange and only for consumers reporting a future loss of MEC. This option is not available in the FFE.	07	Application

SEP Category	Regulatory Authority Under 45 CFR 155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Change in household size	(d)(2)(i) – Gain a dependent or become a dependent *The SEP at (d)(2)(ii) – Loss of dependent due to divorce, legal separation or death is offered at the option of the Exchange and is not currently available in the FFE. **Existing enrollees will generally be limited to their current plan.	A QI gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order. **Coverage Effective Dates:** • Marriage: First of the month after plan selection. **NOTE**: For marriage, at least one spouse must have MEC for one or more days during the 60 days preceding the date of marriage, or meets one of the following criteria: lived for one or more days during the 60 days preceding the qualifying event in a foreign country or a United States territory; or lived for one or more days during the 60 days preceding the qualifying event or during their most recent preceding enrollment period, in a service area where no QHPs were available on the Exchange; or is an Indian as defined by Section 4 of the Indian Health Care Improvement Act. Verification of this requirement has not yet been implemented in the FFE. • Birth, adoption, foster care placement, court order: Retroactive back to the date of the event. **NOTE**: For birth, adoption, placement for adoption, or placement in foster care, or court order, individuals may alternatively request a coverage effective date of the first day of the month following the date of plan selection by calling the Marketplace Call Center.	Birth: 02 Marriage: 32 Adoption/ Foster Care Placement/ Court Order: 05	Application

SEP Category	Regulatory Authority Under 45 CFR 155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Change in primary place of living	(d)(7) – Gain access to new QHPs due to a permanent move *Existing enrollees will generally be limited to plan options within their current plan category.	A QI or enrollee, or their dependent, gains access to new QHPs as a result of a permanent move. The QI, enrollee, or dependent must also have had MEC for one or more days in the 60 days prior to the move, unless the individual meets one of the following criteria: lived for one or more days during the 60 days preceding the qualifying event in a foreign country or a United States territory; or lived for one or more days during the 60 days preceding the qualifying event or during their most recent preceding enrollment period, in a service area where no QHPs were available on the Exchange; or is an Indian as defined by Section 4 of the Indian Health Care Improvement Act. **NOTE**: Moving solely for medical treatment or vacation would not be considered a permanent move for purposes of qualifying for this SEP. **Coverage Effective Dates**: Accelerated prospective coverage effective dates. **NOTE**: At the option of the Exchange, this SEP can be available 60 days prior to the move. However, the FFE does not offer advanced availability for this SEP at this time.	43	Application
Change in eligibility for Exchange coverage or help paying for coverage	(d)(3) – Become newly eligible for QHP coverage	A QI or their dependent becomes newly eligible for enrollment in a QHP due to gaining status as a citizen, national, or lawfully present individual or being released from incarceration. **NOTE**: QIs who change from one lawfully present status to another do not qualify for this SEP. **Coverage Effective Dates**: Accelerated prospective coverage effective dates. **NOTE**: At the option of the Exchange, this SEP can be available 60 days prior to the change in eligibility for QHP coverage. However, the FFE does not offer advanced availability for this SEP at this time.	NE	Application

SEP Category	Regulatory Authority Under 45 CFR 155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Change in eligibility for Exchange coverage or help paying for coverage (continued)	(d)(6)(i-ii) – Become newly eligible or ineligible for APTC, or experience a change in eligibility for CSR **Current enrollees who are newly eligible for CSR are generally limited to either current plan category or Silver plans. ***Current enrollees who are newly ineligible for CSR and are currently enrolled in a Silver plan can now change to a plan one category higher or lower. **** Current enrollees who are newly ineligible for APTC can change to a plan of any category.	An enrollee or their dependent is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR. **Coverage Effective Dates**: Accelerated prospective coverage effective dates. **NOTE**: This SEP is only available to current Exchange enrollees.	FC	Application
Change in eligibility for Exchange coverage or help paying for coverage (continued)	(d)(6)(iv) – Previously in the coverage gap and become newly eligible for APTC **Existing enrollees will generally be limited to plan options within their current plan category.	A QI who was previously ineligible for APTC solely because of a household income below 100 percent of the FPL and who, during the same time frame, was ineligible for Medicaid because the individual was living in a non-Medicaid expansion state, who either experiences a change in household income or moves to a different state resulting in the QI becoming newly eligible for APTC. **Coverage Effective Dates**: Accelerated prospective coverage effective dates. **NOTE**: At the option of the Exchange, this SEP can be available 60 days prior to the move. However, the FFE does not offer advanced availability for this SEP at this time.	EX	CMS Caseworker via Marketplace Call Center

SEP Category	Regulatory Authority Under 45 CFR 155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Change in eligibility for Exchange coverage or help paying for coverage (continued)	(d)(6)(v) – Experience a decrease in household income and new determination of eligibility for APTC *New enrollees are subject to SEP-V (to verify decrease in income and prior coverage)	At the option of the Exchange, a QI and their dependent who experiences a decrease in household income and is 1) newly determined eligible for APTC by an Exchange and 2) had MEC as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 days preceding the Change in Circumstance (CIC). **Coverage Effective Dates**: Accelerated prospective coverage effective dates.	EX	CMS Caseworker via Marketplace Call Center
Change in eligibility for Exchange coverage or help paying for coverage (continued)	(d)(8)(i-ii) – Gain or maintain status as a member of a Federally recognized tribe or a shareholder in an Alaska Native Corporation	A QI who is an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, gains or maintains such status and may enroll in a QHP or change from one QHP to another one time per month. A QI who is or becomes a dependent of an Indian and is enrolled or is enrolling in a QHP through an Exchange on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian. **Coverage Effective Dates**: Accelerated prospective coverage effective dates.	NE	Application
Enrollment or plan error	(d)(4) – Experience an error of the Exchange	A QI's or their dependent's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. **Coverage Effective Dates**: Appropriate date based on the circumstances of the SEP. Typically, retroactive back to the coverage effective date the QI would have gotten absent the error or accelerated prospective coverage effective date, at the option of the QI. **NOTE**: There are some exceptions for certain types of errors.	EX	Marketplace Call Center

SEP Category	Regulatory Authority Under 45 CFR 155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Enrollment or plan error (continued)	(d)(5) – Experience a plan contract violation	An enrollee or their dependent adequately demonstrates to the Exchange that the QHP in which the individual is enrolled substantially violated a material provision of its contract in relation to the enrollee. **Coverage Effective Dates**: Appropriate date based on the circumstances of the SEP. Typically retroactive back to the coverage effective date the QI would have gotten absent the error or accelerated prospective coverage effective date, at the option of the QI.	EX	CMS Caseworker
Enrollment or plan error (continued)	(d)(12) – Material error related to plan benefits, service area, or premium	The enrollment in a QHP through the Exchange was influenced by a material error related to plan benefits, service area, cost-sharing, or premium. A material error is one that is likely to have influenced a QI's, enrollee's, or dependent's enrollment in a QHP. For further details on how this SEP is operationalized, see **Section 5.9**, **Plan Display Errors**. **Coverage Effective Dates**: Appropriate date based on the circumstances of the SEP. Typically, retroactive back to the coverage effective date the QI would have gotten absent the material error or accelerated prospective coverage effective date, at the option of the QI.	EX	Marketplace Call Center

SEP Category	Regulatory Authority Under 45 CFR 155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Other qualifying changes	(d)(9) – Experience an exceptional circumstance	A QI's, enrollee's, or their dependent's enrollment or non-enrollment in a QHP is the result of an exceptional circumstance, as determined by the Secretary of HHS, including being incapacitated or experiencing a natural disaster. The enrollment or non-enrollment of a QI, enrollee, or their dependent in a QHP is the result of an unforeseen event, such as a national emergency, or reflects a first-time requirement for Exchange enrollees. The enrollment or non-enrollment of a QI, enrollee, or their dependent in a QHP is the result of a significant life event or medical need resulting in lack of access to their application or account and the individual, enrollee, or dependent has experienced a change in situation or status that now requires that the individual obtain MEC. This also includes AmeriCorps servicemembers who are starting or ending their service. In rare cases, CMS may consider and provide an SEP on a case-by-case basis when the enrollment in a QHP in which an unintentional network error or network correction may have occurred and the consumers made a plan selection based on information that was grossly inaccurate. **Coverage Effective Dates**: Vary based on circumstances.	EX	CMS Caseworker, Marketplace Call Center (in some cases, Application)
Other qualifying changes (continued)	(d)(10) – Domestic abuse/Spousal abandonment	A QI is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR 1.36B-2, including a dependent or unmarried victim within a household, is enrolled in MEC and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. A dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim. **Coverage Effective Dates**: Accelerated prospective coverage effective dates.	EX	Marketplace Call Center

SEP Category	Regulatory Authority Under 45 CFR 155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Other qualifying changes (continued)	(d)(13) – Resolution of data matching issue (DMI) or verification of citizenship/lawful presence status *This SEP is offered on the FFE but is optional for Exchanges.	The QI provides satisfactory documentary evidence to verify their eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in 45 CFR 155.315. **Coverage Effective Dates**: Appropriate date based on the circumstances of the SEP. Typically, retroactive coverage is back to date of termination.	NE	Marketplace Call Center
Other qualifying changes (continued)	(d)(14) – Newly gains access to an ICHRA, or newly provided with a QSEHRA	The QI, enrollee, or dependent newly gains access to an ICHRA (as defined in 45 CFR 146.123(b)), or is newly provided a QSEHRA, as defined in Section 9831(d)(2) of the Code. A QI, enrollee, or dependent will qualify for this SEP regardless of whether they were previously offered or enrolled in an ICHRA or previously provided a QSEHRA, so long as they are not enrolled in the ICHRA or provided the QSEHRA on the day immediately prior to the triggering event, which is the first day on which coverage under the ICHRA can take effect, or the first day on which coverage under the QSEHRA takes effect. **Coverage Effective Dates**: Individuals who qualify for this SEP have 60 days before their HRA start date to select a QHP, unless the HRA was not required to provide the notice setting forth its terms to them at least 90 days before the beginning of the plan year, in which case they have 60 days before or after their HRA start date to select a QHP. • Plan selection prior to triggering event: First of the month following the triggering event; if the triggering event is on the first day of a month, on the date of the triggering event • Plan selection on or after triggering event: First of the month after plan selection	ICHRA: HR QSEHRA: QS	Application

Exhibit 16 provides examples of coverage effective dates for various SEPs within the FFE.

Exhibit 16: SEP Effective Date Examples

Triggering Event	Triggering Event Date	SEP Start Date	SEP End Date (FFE – 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
Birth*	6/1	6/1	7/31	6/29	6/1 or 7/1
Birth*	8/25	8/25	10/23	9/15	8/25 or 10/1
Birth*	12/26	12/26	2/24	1/13	12/26 or 2/1
Loss of Coverage†	4/28	2/27	6/27	3/10	5/1
Loss of Coverage†	4/15	2/14	6/14	5/20	6/1
Loss of Coverage†	5/12	3/13	7/11	6/7	7/1
Denied Medicaid/CHIP Eligibility**	4/28	4/28	6/27	5/20	6/1
Denied Medicaid/CHIP Eligibility**	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(c)(2), an Exchange has the option of offering the Permanent Move SEP to eligible consumers 60 days before the trigger event. This option is not available through the FFE at this time.

*Per 45 CFR 155.420(b)(2)(i), the Exchange is required to ensure that coverage is effective for a QI or enrollee on the DOB, adoption, placement for adoption, placement in foster care, or effective date of the child support order or other court order. However, QIs may also call the Marketplace Call Center to alternatively elect a coverage effective date for the first of the month following plan selection following accelerated coverage effective rules.

†Per 45 CFR 155.420(c)(2), QIs eligible for loss of coverage SEPs have up to 60 days before or up to 60 days after the triggering event to select a QHP.

**This SEP applies to individuals who applied for coverage during the OEP or due to a qualifying event and then were determined ineligible for Medicaid or CHIP outside of the enrollment period during which they applied.
NOTE: For individuals who are eligible for this SEP, the Exchange must ensure that coverage is effective on an appropriate date based on the circumstances of the SEP. These individuals generally

can request a retroactive coverage effective date back to the coverage effective date they would have received if the FFE had originally determined them eligible for QHP coverage.

NOTE: In the FFE, SEPs currently following accelerated prospective effective date rules are now effective on the first of the month following plan selection.

5.7 SEPs Accessed Outside of the Application Process

The Exchange grants most SEPs through application questions or internal logic on the application. However, there are certain SEPs that eligible individuals generally must access through the Marketplace Call Center and, in some cases, by then having their information reviewed by a CMS Caseworker. These include:

- Error of the Exchange or Misrepresentation in Enrollment Process SEP (granted under 45 CFR 155.420(d)(4))
- Experience a Plan or Contract Violation (granted under 45 CFR 155.420(d)(5))
- Material error related to plan benefits, service area, or premium (granted under 45 CFR 155.420(d)(12))
- Exceptional circumstance SEPs (granted under 45 CFR 155.420(d)(9))
- Victim of domestic abuse or spousal abandonment (granted under 45 CFR 155.420(d)(10))

Some of these SEPs, such as the Error of the Exchange and Exceptional Circumstance SEPs, can be granted when QIs have not yet enrolled in a QHP, while others, such as material errors or some misrepresentation SEPs, may be granted after an enrollment has been effectuated.

Individuals seeking one of these SEPs will need to call the Marketplace Call Center and explain their situation. Call center representatives may be able to determine whether an individual is eligible for an SEP, but in many situations, they forward cases to CMS Caseworkers to determine the individual's eligibility for an SEP. If the SEP is granted and a new enrollment is processed, a record is assigned to the issuer through the Health Insurance Casework System (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 enrollee's request to terminate their prior coverage the day before the new QHP's coverage effective date, pursuant to 45 CFR 155.430(d)(6).

5.8 Exceptional Circumstances SEPs

Exceptional circumstances SEPs authorized by 45 CFR 155.420(d)(9) are generally reviewed on a case-by-case basis. However, CMS identified some specific cases and parameters for which an Exceptional Circumstances SEP is available.

NOTE: Typically, CMS does not consider provider network changes to fall under current SEP authority at 45 CFR 155.420(d)(4) for Errors of the Exchange or SEP authority for plan display errors at 45 CFR 155.420(d)(12). However, in certain extreme cases in which an unintentional network error or network correction occurred and consumers made a plan selection based on information that was grossly inaccurate (e.g., multiple providers and/or hospitals erroneously listed as in-network), CMS may consider that the affected consumers experienced an exceptional circumstance authorized by 45 CFR 155.420(d)(9) and provide an SEP on a case-by-case basis.

5.8.1 SEP for QIs Affected by Emergencies and Major Disasters[55]

Typically, individuals have 60 days from the date of an SEP qualifying event to enroll in a QHP. However, if an individual or their dependents are affected by an emergency or major disaster that is recognized with a formal declaration from the Federal Emergency Management Agency (FEMA) and that emergency or major disaster prevents the individual or their dependents from enrolling within 60 days of the qualifying event, or from enrolling during the OEP, the individual and their dependents will be eligible for an Exceptional Circumstances SEP under 45 CFR 155.420(d)(9) that allows them to complete their Exchange enrollment.

Individuals will be considered "affected by a FEMA-declared emergency or major disaster" and eligible for an Exceptional Circumstances SEP under 45 CFR 155.420(d)(9) if they were unable to enroll during an enrollment period for which they were eligible for, that is, either the OEP or an SEP, due to a FEMA-declared emergency or disaster. To demonstrate this, individuals are required to attest that they meet the following eligibility requirements: 1) they resided in any of the counties eligible to apply for individual assistance or public assistance by FEMA either during the FEMA-designated incident period of the emergency or major disaster or at the time of application for enrollment and 2) they were affected by the emergency or disaster and that it prevented them from completing enrollment.

FEMA-emergency affected individuals have up to 60 days from the end of the FEMA-designated incident period to select a new QHP through the FFE or make changes to their existing QHP enrollment. FEMA-emergency affected individuals can choose to have their coverage start prospectively, pursuant to accelerated effective date rules under 45 CFR 155.420(b)(3)(i), or can request an effective date that would have been applied if they had selected a plan during their original enrollment opportunity. Finally, coverage effective date rules vary based on the date of plan selection and the qualifying event for the enrollment opportunity.

For example, Mary's employer-sponsored health insurance coverage ended on June 1. Because Mary lost MEC, Mary qualifies for an SEP under 45 CFR 155.420(d)(1)(i) and has 60 days from the loss of MEC, through July 31, to select a QHP. However, Mary was unable to complete an FFE application and QHP selection by July 31 because a severe tropical storm flooded the ground floor of Mary's home in Mobile County, Alabama (AL). Mary stayed with relatives in nearby Clark County for several days until the flood waters receded and then spent the next several weeks cleaning up the damage.

On July 7, FEMA announced a Major Disaster Declaration related to the storm and flooding, with an incident period of June 20–22. FEMA designated several AL counties, including Mobile, as eligible to apply for public assistance. As such, even though Mary's SEP for loss of MEC has expired, Mary is now eligible for an Exceptional Circumstances SEP under 45 CFR 155.420(d)(9) and may apply for and select FFE coverage through August 21 (60 days from June 22). If Mary selects a QHP between August 1 and August 15, Mary will be eligible to start coverage prospectively (on September 1, per accelerated effective date rules) or in the past (on July 1 or August 1—effective dates that would have been available if Mary had chosen a plan during the loss of MEC SEP window but after June 20, the FEMA incident start date). Additionally, if Mary selects a plan under this Exceptional Circumstances SEP between August 16 and August 21, Mary will be eligible to start retroactive coverage on July 1 or August 1 (effective dates that would have been available if Mary had chosen a plan during the loss of

[55] A full copy of this guidance is available at https://www.cms.gov/cciio/resources/regulations-and-guidance/fema_sep.

MEC SEP window, but after June 20, the FEMA incident start date), or choose to start coverage in the future, on September 1, per accelerated effective date rules.

Exhibit 17 provides additional samples of qualifying events and coverage dates for FEMA-emergency affected individuals.

Exhibit 17: Sample SEP Coverage Effective Dates for FEMA-Emergency Affected Individuals

Qualifying Event	Date of Qualifying Event	Qualifying Enrollment Period End Date	FEMA Incident Start Date	FEMA Incident End Date	Exceptional Circumstance SEP End Date	Plan Selection Date Example	Available Coverage Effective Date(s)**
Birth or Adoption*	6/1	7/31	6/20	6/22	8/21	8/3	6/1,7/1, 8/1, or 9/1
Birth or Adoption	6/1	7/31	7/5	7/23	9/22	9/21	6/1, 8/1, 9/1, or 11/1
Loss of Coverage	6/1	7/31	6/20	6/22	8/21	8/5	7/1, 8/1, or 9/1
Loss of Coverage	6/23	8/22	6/20	7/22	9/21	9/3	7/1, 8/1, or 9/1
Annual OEP	N/A	12/15	11/2	11/15	1/14	12/19	1/1 or 2/1
Annual OEP	N/A	12/15	11/30	12/10	2/9	2/3	1/1 or 3/1

***NOTE**: Per 45 CFR 155.420(b)(2)(i), the Exchange is required to ensure that coverage is effective for a QI on the DOB, adoption, placement for adoption, placement in foster care, or effective date of the child support order or other court order. However, QI may also call the Marketplace Call Center to alternatively elect a coverage effective date for the first of the month following plan selection or following regular coverage effective rules.

****NOTE**: In the FFE, SEPs currently following regular effective date rules are now effective on the first of the month following plan selection.

To apply for an Exceptional Circumstances SEP, FEMA-emergency affected individuals must contact the Marketplace Call Center at 1-800-318-2596 (TTY:1-855-889-4325) and indicate they were eligible for another enrollment window but were unable to complete their enrollment due to a FEMA-designated emergency or disaster. To expedite this process, FEMA-emergency affected individuals can complete an application on HealthCare.gov directly or with the assistance of a Navigator, agent or broker (A/B), Certified Application Counselor (CAC), or DE Partner, before calling the Marketplace Call Center.

5.8.2 SEP for AmeriCorps/VISTA/National Civilian Community Corps Members[56]

The Corporation for National and Community Service (CNCS), which is a Federal agency, manages and provides grants for the AmeriCorps State and National, VISTA, and National Civilian Community

[56] See https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/SEP-and-hardship-FAQ-5-1-2014.pdf.

Corps (NCCC) programs. These programs provide funding and other support for individuals engaged in national service, and CNCS is required to ensure that the members in these programs have health coverage.

CNCS and its AmeriCorps programs do not provide group health plan coverage to members because members do not have an employment relationship with either CNCS or its grantees. Therefore, CNCS encourages AmeriCorps members to consider seeking coverage through the FFE or an SBE.[57] However, many members begin and end their terms of service outside of the OEP, and other who members receive short-term, limited-duration coverage or self-funded coverage as part of their AmeriCorps service are not able to access QHP coverage in the FFE outside of OEP upon completion of their service as this coverage is not MEC and does not qualify members for the loss of MEC SEP.

In accordance with 45 CFR 155.420(d)(9), and in light of the statutory obligation for health coverage to be provided to the participants in the AmeriCorps State and National, CMS determined that participants and their dependents in the AmeriCorps State and National, VISTA, and NCCC programs are eligible for the Exceptional Circumstances SEP. This SEP applies for individuals who are 1) beginning service in the AmeriCorps State and National, VISTA, or NCCC programs; or 2) individuals who are concluding their service in the AmeriCorps State and National, VISTA, or NCCC programs and are losing access to their short-term, limited-duration coverage or self-funded coverage.

Affected AmeriCorps State and National, VISTA, and NCCC members have 60 days from their triggering event, defined as either the date they begin service or the date they lose access to short-term, limited-duration coverage or self-funded coverage from these programs, to select a QHP through the FFE. Coverage effective dates will be prospective based on the date of plan selection, and these individuals should contact the Marketplace Call Center to request this SEP. They should inform the Marketplace Call Center that they are beginning or concluding service with AmeriCorps State and National, VISTA, or NCCC.

5.9 Plan Display Errors

Plan display errors occur when an enrollment in a QHP through the Exchange was influenced by a material error related to plan benefits, service area, cost-sharing, or premium. CMS considers a plan display error to have occurred only if there was (a) a material error (meaning that is likely to have influenced a QI's, enrollee's, or their dependent's enrollment in a QHP), (b) the error was displayed on Healthcare.gov, and (c) it results in a negative consumer impact. After the start of OEP, CMS reviews data changes made by issuers to determine (a) if the change displays on Healthcare.gov and (b) if the change either reduces a benefit or increases costs to QIs and therefore constitutes a plan display error with a negative consumer impact. If such a plan display error is identified, CMS works with the issuer and applicable state's regulatory authority to provide options for consumer remediation, i.e., either for the issuer to honor the benefit that displayed to consumers at the time of plan selection or for CMS to grant an SEP as outlined in 45 CFR 155.420(d)(12).

Plan display errors may arise when coding on HealthCare.gov causes benefits to display incorrectly or where an incorrect QHP data submission or discrepancy between an issuer's QHP data and its state-approved form filings are displayed to the QI. If such an error is identified, CMS determines whether other QHPs are affected by the same error and reaches out to other affected issuers.

[57] For example, see https://americorpsvista.imglobal.com/my-benefits/health-benefit-plan.

Errors in plan materials, such as directory and drug formulary errors, are not plan display errors and will not trigger a plan display error SEP, regardless of whether they display on external websites or documents linked on HealthCare.gov. In these cases, other consumer protections might apply. For instance, if a drug is no longer on the plan's formulary, the plan is still required to have processes in place that allow the enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber, as appropriate) to request and gain access to clinically appropriate drugs not otherwise covered by a health plan (a request for exception) in accordance with 45 CFR 156.122(c). However, in certain extreme cases in which an unintentional network error or network correction occurred and consumers made a plan selection based on network information that was grossly inaccurate (e.g., multiple providers and/or hospitals erroneously listed as in-network), CMS may consider that the affected consumers experienced an exceptional circumstance authorized by 45 CFR 155.420(d)(9) and provide an SEP on a case-by-case basis.

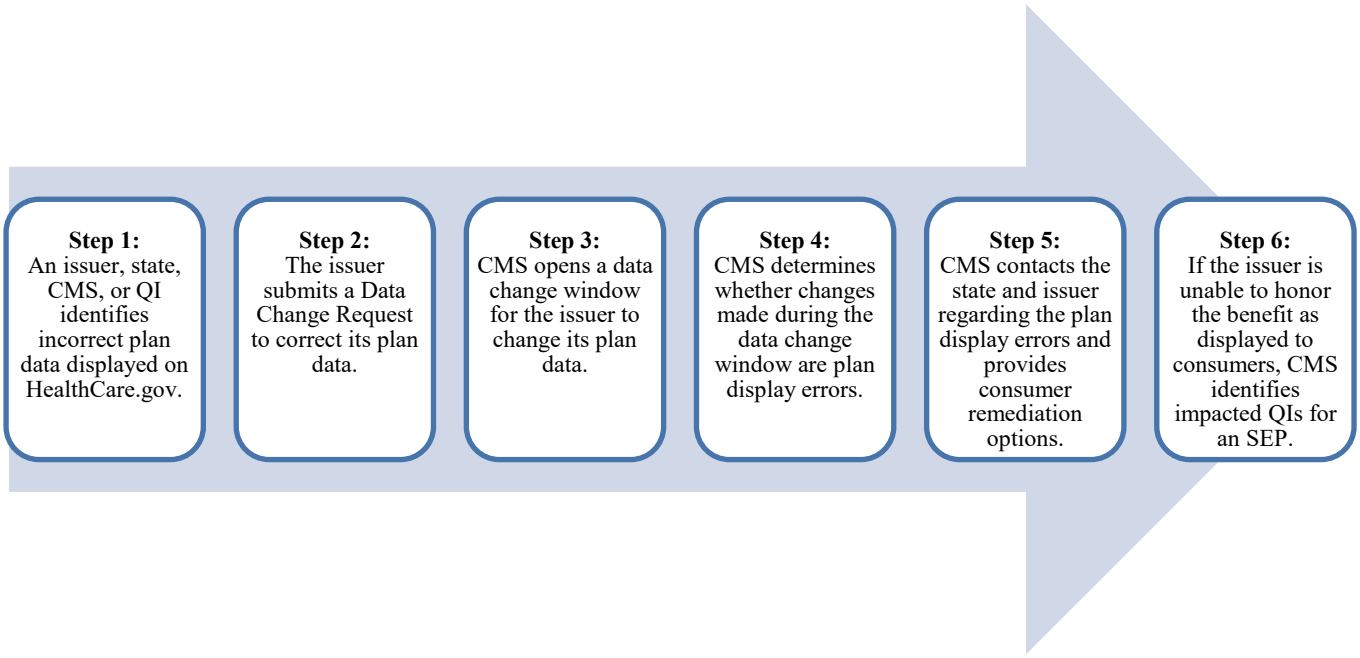
For other plan display errors that exist outside of the Exchange, CMS will consider whether the error constitutes a material contract violation that would be eligible for an SEP pursuant to 45 CFR 155.420(d)(5).

5.9.1 Identifying and Resolving Plan Display Errors

Plan display errors on HealthCare.gov can be identified by issuers, state regulators, QIs, or CMS. CMS encourages issuers to work closely with applicable state authorities and stakeholders to ensure they send CMS accurate plan data to avoid potential plan display errors. If a plan display error is identified, CMS works with the issuer and state to correct the error as quickly as possible during data correction windows (DCWs) to ensure enrollments moving forward are based on accurate plan data. CMS then works with the issuer and state to determine the appropriate remediation approach for impacted QIs.

Exhibit 18 outlines the steps issuers take to correct plan data and the process by which CMS reviews these changes for potential plan display errors.

Exhibit 18: Identifying and Correcting Plan Display Errors That May Qualify for Consumer Remediation



The recommended consumer remediation approach for plan display errors is for issuers to honor the benefit as it displayed to affected QIs at the time of plan selection, if permitted by the applicable state regulatory authority. If the issuer honors the benefit and administers the plan as it displayed for the affected QIs, CMS will not provide affected QIs with an SEP. If the issuer does not or cannot (pursuant to direction from the applicable state authority expresses) honor the benefit as it was displayed at the time of plan selection, then CMS will grant affected QIs an SEP. The SEP will provide the opportunity to select another plan available to the QI, either from the same issuer or another issuer, but the QI is not required to do so if they wish to stay enrolled in their existing plan with the correct benefits.

Exhibit 19 outlines action steps and the timeline that CMS and issuers follow to resolve plan display errors through the consumer remediation process.

Exhibit 19: Resolving Plan Display Errors

Step	CMS Action	State or Issuer Action
1.	CMS takes the following initial actions: • Notifies the impacted state that there was a plan display error that requires consumer remediation. • Advises the state of the consumer remediation process of either honoring the benefit as displayed or offering an SEP. • Provides the state with the Benefit Display Issue record ID used to view plan display error(s).	Within two business days of receiving CMS notification, the state can contact CMS to discuss the remediation process, if desired. If the state does not express any concerns about the remediation process within two business days, to CMS, CMS will contact the issuer to begin the consumer remediation.

Step	CMS Action	State or Issuer Action
2.	CMS then contacts the issuer to: • Notify the issuer that remediation of the plan display error is required. • Share the remediation options of either honoring the benefit as displayed or offering an SEP and the states' preferences, as applicable. • Provide the issuer with the Benefit Display Issue record ID used to view plan display error(s) • Provide templated QI notice language to the issuer to send to affected consumers. This notice informs QIs of the error and of their options to remain in their current plan or choose a different plan.	Within five business days of CMS notification, the issuer: • Communicates to CMS its preferred option for remediation. If the issuer will honor the benefit as it displayed to the QI at the time of plan selection, the issuer must provide CMS with evidence of state authorization to honor the benefit. If the issuer chooses this option, the issuer takes no additional action unless notified otherwise. • If the issuer is unable to honor the benefit, it must notify CMS of its preference that CMS grant an SEP. The issuer must provide a draft QI notice to CMS for review using the templated language provided by CMS.
3.	For an issuer opting to honor the benefit as displayed, CMS will review and resolve the Benefit Display Issue record. For an issuer requesting an SEP, CMS will: • Review the issuer's draft QI notice. • Provide either approval or necessary revisions of draft notice within five business days of receiving the draft notice. **NOTE**: Data changes to address complex or exceptional plan display errors may require additional CMS review.	Within five business days of CMS QI notice approval, the issuer: • Sends the CMS-approved notice(s) to SEP-qualified QIs. • Updates CMS via Benefit Display Issue record with the notice mailing date and count of impacted enrollees. **NOTE**: If the issuer's QI notice requires revisions, the issuer sends the revised QI notice to CMS for re-review and approval.
4.	Upon receiving the mailing date and impacted enrollee count from the issuer, CMS: • Sends the approved notice, mailing date, and impacted enrollee count to the Marketplace Call Center and the Office of Program Operations and Local Engagement. • Coordinates with the Marketplace Enrollment and Eligibility Group to internally flag the impacted consumers to allow the consumers to access their Plan Display Error SEP. • Reviews and resolves the Benefit Display Issue record.	

5.9.2 Processing Plan Display Error Consumer Remediation

Under 45 CFR 156.1256, issuers must notify their enrollees of material plan or benefit display errors and the enrollees' eligibility for an SEP within 30 calendar days after being notified by the FFE that the error has been fixed, if directed to do so by the FFE. See **Appendix D – Sample Plan Display Error Notice** for a sample notice an issuer may send to impacted individuals with language indicating that an SEP is being offered due to a plan display error.

Under 45 CFR 155.420(b)(2)(iii), an Exchange may provide for a coverage effective date that is appropriate based on the circumstances, which will generally be either 1) retroactive coverage based on the date of the SEP-triggering event, which provides the enrollee their initially intended coverage effective date; or 2) prospective coverage based on the date of the plan selection during the SEP window, which provides the enrollee future effective dates under 45 CFR 155.420(b)(3)(i).

In the case of a retroactive coverage date or retroactive termination date, the former plan (i.e., the plan the consumer enrolled in due to the plan display error) repays premiums and reverses claims payments. The gaining plan (i.e., the plan into which the consumer is enrolling through the SEP) collects premiums for all months of coverage and adjudicates the claims from previous months. If a QI chooses a new plan with a new issuer then, regardless of coverage effective date, the QI's deductibles and accumulations toward the maximum out-of-pocket limit reset starting with the new date of coverage.

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

CMS allows any SEP-qualified individual already enrolled in a QHP to select a new QHP by calling the Marketplace Call Center. The Marketplace Call Center will help the QI update their information as needed and complete the process of selecting a QHP. QIs electing prospective coverage may also use HealthCare.gov or the platform where they made their initial plan selection to select a new QHP. QIs generally have 60 days from when they are notified by their issuer of the plan display error to select a new plan.

6. PREMIUMS (APPLICABLE TO THE INDIVIDUAL MARKET FFE, QHPS/QDPS)

6.1 Introduction

The Federally-facilitated Exchange (FFE) has established guidelines regarding binder payments (typically the first month's payment) and issuer deadlines for payment of the binder payment at 45 CFR 155.400(e). Under these rules, issuers have discretion to set the deadline for paying binder within certain parameters, but deadlines set by issuers must be applied consistently and in a non-discriminatory manner. In general, when an enrollment is cancelled due to an enrollee's failure to pay the binder payment by the specified due date, issuers cannot grant enrollee requests to reinstate coverage unless the cancellation was a result of issuer or Exchange error (see **Section 8**, **Reinstatements (Applicable to Individual Market FFE, QHPs/QDPs)**, for more information on reinstatements). However, for information about permissible binder payment deadline extensions, see **Section 6.1.1**, **Binder and Premium Payment Extensions Directed by the Exchange or State Authority**.

For the purpose of enrollment in a Qualified Health Plan (QHP), issuers can set reasonable standards for determining when a payment is received, such as by considering payment received when an Electronic Fund Transfer (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). If a binder payment made by an enrollee is returned due to insufficient funds and the deadline for making the binder payment has already passed, the issuer should cancel the enrollee's coverage (if effectuated), following the process outlined in **Section 2.4.3**, **Cancellations in the Individual Market FFE**. Issuers should ensure that the electronic payment information they have on file for an enrollee is current. If an enrollee was previously enrolled with an issuer and chooses to enroll with the issuer again (after not being enrolled for a period of time), issuers should not automatically use the electronic payment information from the previous period of enrollment to collect the binder payment. Instead, the enrollee should be allowed to submit updated payment information or confirm with the issuer that the payment information on file is still current.[58]

6.1.1 Binder and Premium Payment Extensions Directed by the Exchange or State Authority

Pursuant to 45 CFR 155.400(e)(2), the FFE will allow issuers to reasonably extend binder payment and other premium payment deadlines, including for individuals receiving APTC, in the following circumstances:

- Billing or enrollment problems due to technical errors[59].

[58] See 45 CFR 156.265, which requires that issuers must accept enrollment transactions sent by the Exchange, and 45 CFR 155.400(f), which specifies that the Exchange may provide requirements to issuers regarding the processing of electronic transactions for enrollment.

[59] In general, technical errors with enrollment or billing systems are one-time or limited problems with an issuer's systems that prevented or delayed collection of premiums. This would not include ongoing system limitations or systemic issues that, by design, prevent an issuer from collecting premiums or otherwise complying with CMS requirements. For example, an issuer's general inability to collect premium payments below a set amount would not be considered a technical error under this provision.

- Billing or enrollment problems that result from high volume.[60]
- At the direction of applicable state or Federal authorities, including due to natural disasters and other emergencies.

For APTC audits for plan year 2023 and beyond, CMS expects issuers to maintain documentation of their internal policies relating to 45 CFR 155.400(e)(2) and the aforementioned permitted extensions, including documentation of applicable state regulatory requirements or approval and standard operating procedures (SOPs) that demonstrate that any premium payment deadlines permitted to be extended under state or Federal guidance were applied uniformly. Information about policy-based payment (PBP) audits can be found in **Section 18**, **Policy-Based Payment Two-Phase Audit Approach Overview**.

6.1.2 Effectuation of Prospective Coverage Under Regular Coverage Effective Dates

For prospective coverage to be effectuated under regular coverage effective dates, as provided for in 45 CFR 155.410(f) and 155.420(b)(3)(i), the binder payment must consist of the first month's premium, and issuers may set the deadline for making the binder payment no earlier than the coverage effective date and no later than 30 calendar days from the coverage effective date. In general, issuers should only effectuate coverage if the enrollee makes the binder payment by the deadline the issuer has set, subject to the issuer's premium payment threshold policy, if any.

6.1.3 Effectuation of Prospective Coverage Under Special Effective Dates

In instances where issuers are processing enrollments with prospective coverage to be effectuated under special effective dates, as provided for in 45 CFR 155.420(b)(2), such as in connection with gaining access to new QHPs as a result of a permanent move, getting married, or losing coverage, the binder payment must consist of the first month's premium, and issuers may set the deadline for making the binder payment no earlier than the coverage effective date and no later than 30 calendar days from the date the issuer receives the enrollment transaction or the coverage effective date, whichever is later.

6.1.4 Effectuation of Retroactive Coverage Under Retroactive Effective Dates

For coverage to be effectuated under retroactive effective dates as provided for in 45 CFR 155.420(b)(2), such as in connection with error of the Exchange under 45 CFR 155.420(d)(4), the binder payment must consist of the premium due for all months of retroactive coverage through the first prospective month of coverage, and issuers may set the deadline for making the binder payment no earlier than 30 calendar days from the date the issuer receives the enrollment transaction or Health Insurance Casework System (HICS) case establishing the retroactive start date. If the enrollee pays only the premium for one month of coverage by the deadline, only prospective coverage should be effectuated, in accordance with regular effective dates. The issuer must receive full payment (or payment within the premium payment threshold in accordance with 45 CFR 155.400(g) and **Section 6.3**, **Premium Payment Threshold**, if the issuer utilizes such a threshold) from the enrollee for any applicable binder payment by the applicable premium payment deadline. Issuers may not grant grace periods for payment of the binder payment.

[60] Binder and premium payment deadline extensions are not permissible when billing or enrollment problems result from issuers configuring their systems in a way that cannot handle a reasonable volume of billing and enrollment data.

When a qualified individual (QI) enrolls with a retroactive effective date, a prospective coverage effective date may be conveyed to the issuer via an 834 transaction due to technical constraints, and the retroactive coverage date identified 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 for prospective coverage in accordance with but should adjust the binder billing to reflect retroactive binder rules. If by the due date the QI pays at least the first month's premium but less than all outstanding premium due, subject to the issuer's payment threshold policy, if applicable, the QI's enrollment would be effectuated for prospective coverage. Once the issuer processes the HICS case and receives premiums due, the retroactive coverage can be effectuated, with the correct effective dates reported to the FFE by the issuer via Enrollment Data Alignment (EDA).

When issuers add 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. Failure to pay outstanding premium on an effectuated enrollment that is not already in delinquency by the applicable due date would trigger the applicable grace period.

6.1.4.1 Examples

Example 6A: On June 10, the enrollee contacts the Marketplace Call Center to request a Special Enrollment Period (SEP) pursuant to 45 CFR 155.420(d)(4). The enrollee informs the Marketplace Call Center that although they were enrolled in QHP B with a coverage effective date of January 1, they should have been enrolled in QHP A instead. The Marketplace Call Center sends their case to a member of the FFE casework team, who finds that the enrollee was enrolled in the wrong QHP. On July 2, the FFE sends the QHP B issuer a retroactive cancellation transaction. The QHP B issuer reverses the enrollee's submitted claims and refunds the premiums they paid for that year's coverage. Also, on July 2, the Exchange sends the QHP A issuer an 834 transaction enrolling the enrollee with a coverage effective date retroactive to January 1. The enrollee's share of premium after applying their advance payments of the premium tax credit (APTC) is $100 per month. The QHP A issuer receives the 834 transaction on July 2, and, pursuant to 45 CFR 155.400(e)(1)(iii), bills the enrollee for all outstanding prospective and retroactive premiums ($700 of premiums for retroactive coverage and $100 of premiums for August, which will also be due before the binder due date), 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 their coverage with a retroactive effective date of January 1.

Example 6B: A QI is eligible for retroactive enrollment in QHP A with the same dates as Example 6A. A prospective coverage effective date is conveyed to the issuer via an 834 transaction, but the retroactive coverage start date of January 1 is conveyed in an associated HICS case. Before the due date, the enrollee pays the QHP A issuer $100 and makes no further payment. Since the QHP A issuer received the 834 enrollment transaction on July 1, the issuer effectuates the enrollment effective August 1, not January 1.

Example 6C: On July 14, a QI receives a final eligibility appeals decision finding that the QI should be granted an SEP to enroll in coverage based on a qualifying life event that occurred in February of that year. Upon receipt of the appeal decision, the QI enrolls in a QHP with a requested coverage effective date of March 1. Because this request for coverage with a retroactive effective date does not arise from an SEP subject to verification, the QI must pay premium in accordance with 45 CFR

155.400(e)(1)(iii), which states that the QI must pay a binder payment of premium due for all months of retroactive coverage, plus the first prospective month of coverage, or an amount sufficient to satisfy any applicable premium payment threshold, consistent with 45 CFR 155.400(g). The monthly member-responsible portion of premium is $100. In order to effectuate coverage with an effective date of March 1, the QI must pay $600, or an amount sufficient to satisfy any applicable premium payment threshold, consistent with 45 CFR 155.400(g), which would satisfy premium amounts for March through July and for the prospective month of August. By the binder payment deadline, the QI paid the QHP issuer only $100. Under the rule at 45 CFR 155.400(e)(1)(iii), the QHP issuer should effectuate prospective coverage only, with a coverage effective date of August 1, in accordance with regular effective date rules.

6.2 Payment for Re-enrollments

For renewals of effectuated coverage, a binder payment is not required as the renewal is a continuation of effectuated coverage, and no new effectuation is required. The FFE also does not require a binder payment for passive re-enrollments that continue effectuated coverage in another plan within the same product (or in a different plan in a different product offered by the same issuer, if the current product will no longer be available to the enrollee, consistent with the hierarchy for re-enrollment specified at 45 CFR 155.335(j)(2)) for the same subscriber.[61] This means that no binder payment is required when subscribers in already effectuated policies are auto re-enrolled into coverage offered by the same issuer. Active re-enrollments of effectuated subscribers, however, require a binder payment when the enrollee selects a plan outside the product that includes the re-enrollment plan identified by the issuer in its Plan ID Crosswalk Template, consistent with 45 CFR 155.335(j). For instance, an issuer offers Products 1, 2, and 3, each with Silver ("S") and Gold ("G") plans. If an enrollee is enrolled in 1S, which remains available, and wants to actively select 1G during an annual Open Enrollment Period (OEP), that individual can do so without being required to make a binder payment. However, if the enrollee actively selects 2S, 2G, 3S, or 3G, a binder payment is required.

Thus, for continuing effectuated coverage, either due to renewal or certain re-enrollments, as described previously, 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 FFE. In such cases, non-payment of the January premium by the due date set by the issuer will trigger the applicable grace period. Where enrollees have effectuated coverage as a dependent on another subscriber's coverage, and are enrolling as subscribers into the same plan, most typically due to adult children aging off their parent's policy and enrolling into their own policies, such enrollments are new enrollments that require binder payments to effectuate.

Alternate enrollments, for QHP enrollees whose current-year coverage is no longer available through the Exchange, and for whom a plan offered by a different issuer is selected, are new enrollments, not renewals, and thus require a binder payment to effectuate. Alternate enrollments are indicated by the transaction's Additional Maintenance Reason Code (AMRC) of PASSIVE REENROLL – NEW TO 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 or for whom an

[61] Product is defined at 45 CFR 144.103.

alternative plan selection with a different issuer is made by the FFE as part of the Batch Auto Re-enrollment (BAR) process must be promptly refunded.

To summarize, issuers must collect a binder payment to effectuate coverage in the following re-enrollment scenarios:

- Alternate enrollments, where an enrollee is being passively re-enrolled with a different issuer (i.e. different Health Insurance Oversight System [HIOS] ID) for the new plan year.
- Active re-enrollments in which an enrollee is selecting a different product than the one identified in the issuer's Plan ID Crosswalk Template.
- Active re-enrollments in which an enrollee selects a plan with a different issuer.

Issuers are not required to collect a binder payment in the following re-enrollment scenarios:

- Passive re-enrollments in which the enrollee is being re-enrolled with the same issuer (i.e. same HIOS ID, and regardless of whether they are cross-walked to a different product).
- Active re-enrollments in the same product, including selection of a plan with a different metal level.
- Active re-enrollments in which an enrollee is selecting a different product, but the product is the one identified on the issuer's Plan ID Crosswalk Template.

6.3 Premium Payment Threshold

In accordance with 45 CFR 155.400(g), QHP and Qualified Dental Plan (QDP) issuers may implement a premium payment threshold policy for their plans offered through the FFE. 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. Issuers who choose to implement such a policy are required by regulation to select a reasonable threshold level, which are defined in 45 CFR 155.400(g).

QHP and QDP issuers that choose to apply a premium payment threshold policy must apply the policy in a uniform manner to all enrollees. Issuers that adopt a premium payment threshold policy are expected to utilize such a threshold policy for the entire plan year. 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, but the QHP or QDP issuer must still effectuate or continue the enrollment, as applicable.

If the enrollee makes subsequent premium payments such that the total amount paid (including for past-due premiums) is not the full amount due but is within the threshold, the QHP or QDP issuer must consider the enrollee to be current on all payments due for the purpose of determining whether to place the enrollee into an applicable grace period. If the enrollee continues making premium payments (including past-due premiums) in an amount less than the amount due, then eventually the amount will accumulate and may increase beyond the threshold. If that occurs, the enrollee's account has become past-due and the enrollee will be subject to the grace period for failure to pay premiums.

If, at the end of the applicable grace period, the enrollee has made payment(s) sufficient to bring their total enrollee-responsible portion of premium paid within the threshold adopted by the issuer, the issuer must consider the enrollee to be in good standing and may not terminate the enrollee for non-payment of premium.

Issuers are permitted to implement premium payment thresholds based on a percentage of the enrollee-responsible portion of the overall premium.[62] Under such a threshold, issuers 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, which must be set at 95 percent or more of the enrollee's net premium.[63]

Issuers must apply the policy uniformly to the initial premium payment and/or any subsequent premium payments, and to any amount outstanding at the end of a grace period for non-payment of premium. Thus, adoption of such a premium payment threshold means that an issuer would 1.) effectuate an enrollment, 2.) not place an enrollee in a grace period, and 3.) not terminate enrollment after exhaustion of the applicable grace period, for enrollees who have made payment(s) totaling an amount within the issuer's adopted threshold.

Exhibit 20 illustrates an example of the net premium percentage-based payment threshold policy in action.

Exhibit 20: Net Premium Percentage-Based Payment Threshold Lifecycle

Date	Action	Comments
December 10	QI selects QHP ($100 enrollee-responsible portion after APTC)	The QHP issuer has a premium payment threshold of 95 percent.
December 16	Enrollee billed $100 for first month's premium	The 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	The issuer applies $3 to January coverage and $94 to February coverage. However, $97 out of the balance due of $103 is not within the threshold, 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 past-due from March, and $6 past-due from February	The total amount billed is $206. No payment is received from the enrollee.

[62] The enrollee responsible portion is equal to the total premium minus APTC.
[63] 45 CFR 155.400(g)(1)

Date	Action	Comments
April 16	Enrollee billed $100 for May coverage, $100 past-due from April, $100 past-due 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 $302	The issuer applies $6 February (paid in full), $100 to March (paid in full), and $96 to April. Because the enrollee has paid the outstanding amount, within the applicable premium threshold amount, the grace period ends, and the enrollee exits delinquency.
April 30	Enrollee makes no additional payment	No additional payment is received by April 30. However, because the enrollee had made payments of more than 95 percent of the total enrollee-responsible portion of premium before the end of the grace period, the grace period was not exhausted without the enrollee paying all outstanding premiums, subject to the applicable premium payment threshold, so the issuer may not terminate the enrollee's coverage for non-payment of premium.

6.4 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 APTC and who upon failing to pay their premiums timely, are receiving APTC. An enrollee who is eligible for APTC, but elects not to receive any APTC, 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 rules.

In the case where an enrollee receiving APTC is enrolled in both a QHP and a QDP, if the APTC 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 APTC are applied and paid only for the QHP.

To avoid termination, an enrollee must pay all outstanding premiums in full, or within the tolerance of any applicable premium payment threshold, prior to the end of the applicable grace period. A grace period does not "reset" when a partial payment is made, and "rolling" grace periods, where payment of

one month's premium when more than one month's premium is outstanding during the grace period would restart the three-consecutive-month grace period, are not permitted.

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 their coverage was terminated for non-payment. Additionally, during the annual OEP, enrollees 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. The QI is required to pay the first month's premium in accordance with 45 CFR 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 Exchange, as applicable.

Appendix B – Sample Non-Payment Notice for the Individual Market 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 the appendix are not required but are offered as recommendations for elements in the plan's notice of non-payment when an enrollee receives APTC.

6.4.1 Timeliness Requirement for Delinquency Notices

In the 2024 Notice of Benefit and Payment Parameters,[64] CMS finalized a requirement in 45 CFR 156.270(f) that, beginning on June 18, 2023, issuers are required to send notices of payment delinquency promptly and without undue delay. CMS defines promptly and without undue delay as within 10 business days of the date an issuer should reasonably have discovered the delinquency. Notices must be sent for all enrollees who become delinquent on premium payments, regardless of whether they are receiving APTC. Issuers may combine notices, including by leveraging existing monthly invoices, to notify enrollees of payment delinquency and the associated consequences, consistent with the requirements in 45 CFR 156.270(f).

6.4.2 Examples

Example 6D: An enrollee is eligible for, but has elected not to receive, APTC. The enrollee's monthly premium is $200, and the issuer does not make use of a premium payment threshold. The enrollee, whose coverage was effectuated for May, has not paid the June premium, which was due on June 1. The QHP issuer's standard policy, in accordance with applicable state law, is to allow a one-month grace period for enrollees not receiving APTC, but the coverage will end at the end of the month for which the last full payment is made. On June 10, 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 FFE containing a termination effective date of May 31. The issuer should refund the $50 premium for June in accordance with applicable state law, as no coverage was provided for June once the coverage was retroactively terminated to May 31.

Example 6E: An enrollee receiving APTC is responsible for a $150 monthly premium payment, and the issuer does not make use of a premium payment threshold. The enrollee'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 runs through August 31. The enrollee

[64] 88 FR 25740

fails to make any payment for the July premium and now owes the QHP issuer $300. On July 10, the enrollee pays $200. Since the enrollee has not paid the entire outstanding premium for which they are responsible, the enrollee remains in the three-consecutive-month grace period that started June 1. The enrollee fails to make any further payments, and on August 31, the QHP issuer sends an 834 termination transaction to the FFE containing a termination effective date of June 30. The QHP issuer can keep $150 of the $200 payment to cover June premium but should refund the remaining $50 in accordance with applicable state law, as no coverage was provided for July once the coverage was retroactively terminated to June 30.

Example 6F: Circumstances are the same as Example 6E except that on July 10, the enrollee pays $300 instead of $200. Since the enrollee has paid the entire outstanding premium balance for which they are responsible, the enrollee is no longer in the grace period. However, if the enrollee fails to make full payment for August by the payment due date, the enrollee will enter into a new three-consecutive-month grace period beginning August 1.

Example 6G: Circumstances are the same as Example 6E except that the issuer utilizes a 95 percent premium payment threshold. The enrollee pays no premium in June or July. The issuer bills the enrollee for August premium ($150), which raises the total premium owed by the enrollee to $450. The enrollee pays $430 on August 20 and makes no further payments before August 31. Because the enrollee made a payment within the 95 percent tolerance of the issuer's premium payment threshold, the issuer declines to terminate for non-payment of premium at the end of the three-consecutive-month grace period. The enrollee still owes the $20 outstanding and will enter the applicable grace period if they do not pay $170 ($150 for September premium and $20 outstanding from the grace period), or an amount within the premium payment threshold tolerance, for September coverage.

6.4.3 Prohibition of Option to Condition New Enrollment on Payment of Past-Due Premium

Previously, issuers had the option to condition new enrollments on payment of past-due premiums under the 2017 Market Stabilization Rule,[65] which introduced CMS's modified interpretation of the guaranteed availability rules with respect to non-payment of premiums. Under that interpretation, a QHP issuer would not be considered to violate the guaranteed availability requirements if the QHP issuer attributes a premium payment for coverage under the same or a different product to premiums due to the same QHP issuer within the prior 12 months and refuses to effectuate new coverage for failure to pay premiums. QHP issuers who adopted this premium payment policy, as well as any QHP issuers who did not adopt the policy but were within an adopting issuer's controlled group, were required to clearly describe the consequences of non-payment on future enrollment, prior to the non-payment of premiums, for that non-payment to be considered past-due premiums subject to this new interpretation. That description was required in any enrollment application materials, and in any notice that was provided regarding non-payment of premiums, in paper or electronic form.

However, in the 2023 Notice of Benefit and Payment Parameters,[66] which appeared in the May 6, 2022, Federal Register, CMS reinterpreted the guaranteed availability requirements. Effective July 1, 2022, issuers may no longer condition new enrollments on payment of past-due premiums or attribute premium payments for new coverage to past-due premiums owed to the issuer (or another issuer in the same controlled group). If an enrollee's coverage is terminated by an issuer for non-payment of

[65] Patient Protection and Affordable Care Act; Market Stabilization, Final Rule, 82 FR 18346 (April 18, 2017)
[66] 87 FR 27208

premiums and the former enrollee subsequently re-enrolls with that same issuer or another issuer (including an issuer in the same controlled group) either through an SEP or the annual OEP, the issuer must effectuate the former enrollee's coverage and may not attribute any payments made by the former enrollee toward the new coverage to the outstanding premium owed. The outstanding premium owed by the enrollee is not forgiven, however, and issuers may attempt to collect the premium owed by enrollees whose coverage has been terminated due to non-payment of premiums. [67]

6.4.4 Enrollment Transactions Received for a Subscriber Whose Coverage Is Being Terminated

From time to time issuers may receive from the FFE Maintenance 834 (M834) transactions to update enrollments on policies that the issuer had terminated in its records, because the FFE has not yet recorded the termination. This can occur because of timing issues in EDA and is complicated by the retroactive termination dates of expired APTC grace periods. For example, an issuer with an enrollee who enters an APTC grace period in February that expires at the end of April can only send a non-payment termination transaction effective February 28 to the FFE after the grace period ends, in early May at the earliest. It is not uncommon for an enrollee to report life changes during the grace period months, which are sent as M834 transactions because during that time the FFE records current coverage. The FFE may continue to receive and send updates even later if the issuer delays sending the termination or the FFE does not immediately process it.

The analysis of whether an issuer must enroll (subject to binder) an applicant for whom it receives an M834 on a policy it has terminated or is terminating generally hinges on whether the transaction indicates a new policy issuance subject to guaranteed availability rules, which must be effectuated subject to binder; or is merely an update to a continuous original enrollment that is in the process of terminating. The following rules apply on a general basis, but issuers must assess each enrollment on a case-by-case basis to ensure that they are not improperly rejecting enrollments that should be effectuated.

6.4.4.1 Determining Whether an Enrollment Transaction is an Update to a Continuous Enrollment or Potential New Enrollment

An issuer must first determine whether the M834 is an update to a continuous enrollment or is a potentially new enrollment subject to binder. In the context of M834 transactions, to determine whether the change to an enrollment reflects a new enrollment, or an update to a continuous enrollment, issuers should look to see 1) whether the effective date is before or after the end of the delinquent policy's grace period (either the APTC or state grace period, as applicable) and 2) whether the effective date occurs during an SEP or OEP. Potential new enrollments, where the effective date on the M834 transaction occurs after the end of the applicable grace period, will generally have the effect of creating a gap in coverage between the termination of the current coverage (meaning the date the APTC grace period ends, if applicable) and the effective date of the change requested by the M834

[67] On June 25, 2025, the Department of Health and Human Services (HHS) published the Marketplace Integrity and Affordability Final Rule (90 FR 27074), which finalized amendments to 45 CFR 147.104(i) that reversed the existing policy prohibiting an issuer from denying coverage due to an individual or employer's failure to pay premiums owed for prior coverage, including by attributing payment of premium for new coverage to past-due premiums from prior coverage. This provision was scheduled to go into effect on August 25, 2025.Pursuant to an order of the Federal district court for the District of Maryland in City of Columbus v. Kennedy, No. 25-cv-2114-BAH (D. Md.), this provision has been vacated.

transaction. However, as previously noted, this is merely a guideline, and determinations should be made on a case-by-case basis.

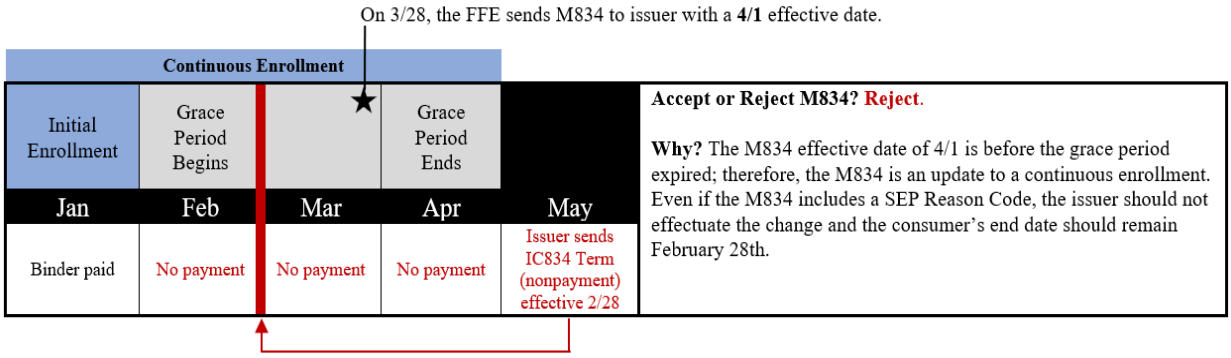
- **Is there an SEP or is it during the OEP?** An issuer must also determine whether the M834 transaction indicates eligibility for an SEP. In general, outside of open enrollment, an M834 transaction without an SEP on a policy the issuer has already validly terminated in its records should not be effectuated. Instead, the issuer should take the non-SEP transaction as a reminder to finish aligning its record with the FFE by using Inbound 834 (IC834), Enrollment Data Reconciliation, or Enrollment Resolution and Reconciliation (ER&R) to ensure that the FFE records the appropriate termination date.
- M834 active transactions (policy transaction is not 11) with or without indication of an SEP during the OEP are considered potential new enrollments if the effective date of the change requested by the M834 transaction is after the end of the applicable grace period. When this happens, an issuer must effectuate an enrollment under an M834 transaction, subject to a binder payment requirement if it receives an active (policy origin not equal to 11) non-SEP M834 with a January 1 effective date for an enrollee whose coverage was passively renewed, and who entered an APTC grace period in September that expired at the end of November (with a September 30 termination date). This is because January 1 falls after November 30, the end of the grace period. Should the enrollee make the binder payment for the January 1 coverage by the due date, there is a gap in coverage spanning November and December (between the termination of the original policy effective September 30, and the start of the new policy on January 1), and thus the transaction reflects a new policy issuance subject to guaranteed availability.
- As discussed previously, if the M834 active transaction for an already issuer-terminated policy indicates eligibility for an SEP, then the analysis on whether to effectuate the transaction depends on whether the transaction is updating a continuous enrollment (do not effectuate) or is a new enrollment (effectuate, subject to binder payment requirement). Note that if the enrollee in an APTC grace period selects a new product during their SEP or OEP, the enrollment should be considered new and should be effectuated, subject to timely payment of the binder payment, without regard to whether the effective date falls after the end of the grace period. This is because active product changes are not considered continuous enrollments (see Example 6L).
- If an issuer that has previously terminated an enrollment must later enroll the same QIs because the FFE sent a M834 SEP or active OEP transaction with an effective date after the end of the applicable grace period and the QI timely pays the binder payment, the issuer will need to establish a gap in the FFE's policy record in EDA. If the new coverage takes effect on a date other than January 1, the issuer will need to use ER&R to acquire a new FFE Policy ID for the new coverage and may use EDA to apply the applicable rates for the newly enrolled enrollees based on their age as of the new enrollment rather than the original start date. The process for using a dispute to create a gap in coverage and assign a new FFE Policy ID to the new policy is described in **Section 6.4.4.3**, **Using ER&R Disputes to Establish a New Exchange Assigned Policy ID for New Policies Effectuated Following a Gap in Coverage**.
- Active OEP enrollments with January 1 start dates that fall after the end of the pervious policy's grace period do not need a new FFE Policy ID, since the FFE already automatically assigns new FFE Policy IDs to coverage continuing into the new plan year; however, the issuer will need to use any channel of EDA to terminate the original policy.

6.4.4.2 Examples

Example 6H: An issuer in early May terminated coverage for an enrollee receiving APTC for nonpayment of premiums, effective February 28. Before the FFE processed the termination, the enrollee reported a life change, triggering the FFE to send an M834 transaction to the issuer with an effective date of April 1. Because April 1 is before the grace period expired, the M834 is an update to a continuous enrollment, and even if the M834 reflects that the enrollee was eligible for an SEP, the issuer should not effectuate the change to the enrollment and should maintain the February 28 termination date.

Exhibit 21 illustrates the sequence of events described in Example 6H.

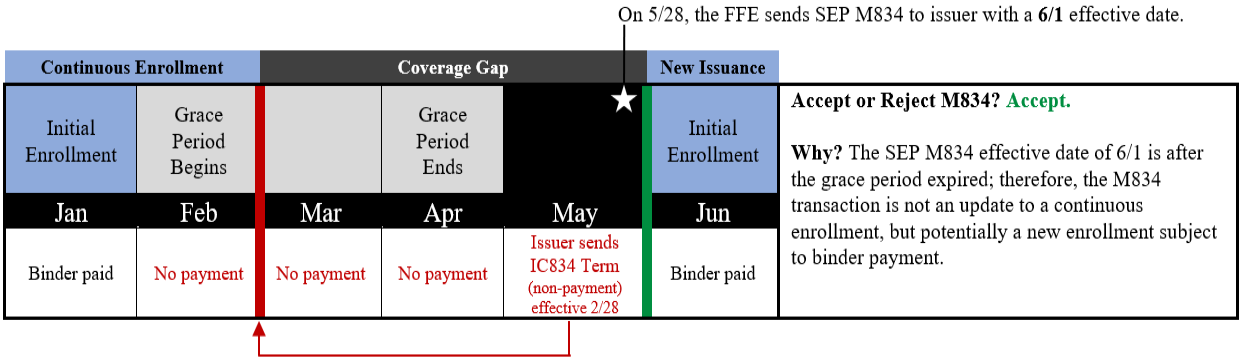
Exhibit 21: Example Timeline



Example 6I: Same facts as Example 6H, except that the M834 transaction has an SEP with an effective date of June 1. June 1 is after the expiration of the APTC grace period, so the M834 transaction is not an update to a continuous policy but rather a potentially new enrollment subject to a binder payment requirement, if the following additional criteria are met.

Exhibit 22 illustrates the sequence of events described in Example 6I.

Exhibit 22: Example Timeline



Example 6J: A consumer enrolls in coverage effective January 1, without APTC. The enrollee pays January and February's premium but does not pay March's premium by the issuer's deadline of March 1. The enrollee's state grace period rules require the issuer to provide the enrollee with a 10-day grace period, after which the issuer must terminate coverage effective the last day of the most recent paid-through month, if the enrollee fails to pay past-due premiums. The enrollee does not pay March's premium by March 11, so the issuer terminates coverage effective February 28. Before coverage was terminated, the enrollee reported a life change, which triggered the FFE to send an M834 transaction to

the issuer with an effective date of March 1. Because March 1 was before state grace period expired, the M834 is an update to a continuous enrollment, and the issuer should maintain the February 28 termination date.

6.4.4.3 Using ER&R Disputes to Establish a New Exchange Assigned Policy ID for New Policies Effectuated Following a Gap in Coverage

When an issuer must effectuate a new policy while terminating the original policy, it must submit an ER&R dispute to create a gap in coverage and trigger the creation of a new Exchange Assigned Policy ID. To accomplish this, issuers should complete the following.

For policies terminated by the issuer using IC834 after the M834 (with an SEP) was processed by the FFE:

- Since the IC834 was submitted by the issuer after the M834 was processed, the new segment created from the SEP will be cancelled.
- The issuer must submit an ER&R dispute requesting a reinstatement of the cancelled segment using the Enrollment Dispute Form.
  NOTE: The issuer must confirm the latest Reconciliation Inbound (RCNI) file submitted to CMS shows both coverage spans; otherwise, the dispute will be rejected.
- Using the Discrepancy Dispute tab, the issuer will choose Issuer End Date Later Than FFM option and populate the Issuer Value field with the new end date. The issuer should use the FFE Inventory Number associated with the coverage period needing reinstatement.
- Once the correction is applied, the previously cancelled segment will be reinstated into a new policy.
- CMS will generate a new Exchange Assigned Policy ID for the reinstated policy.
- The terminated policy will maintain the original coverage start and end dates submitted by the issuer.
- The issuer will need to update the RCNI with the new Exchange Assigned Policy ID once provided by the ER&R contractor.

For policies not terminated by the issuer using IC834 after the M834 (with an SEP) was processed by the FFE:

- The issuer must submit an ER&R dispute using the Enrollment Dispute Form to process the termination for non-payment on the first segment.
  NOTE: The issuer must confirm the latest RCNI submitted to CMS shows the appropriate coverage dates for each segment of the policy; otherwise, the dispute will be rejected.
- Using the Discrepancy Dispute tab, the issuer will choose the Issuer End Date Earlier than FFM option and populate the Issuer Value field with the new end date. Issuers should ensure the proper termination or cancellation reason code is included if the end date is earlier than December 31. To populate the FFM Internal Record Inventory Number field, the issuer should use the inventory number associated with the coverage period needing the earlier termination date applied.
- Once the correction is applied, the ER&R contractor will accept the termination of the initial segment allowing for a gap in coverage.
- CMS will generate a new Exchange-Assigned Policy ID for the second segment created by the SEP.

- The first segment will maintain the original Exchange-Assigned Policy ID and be updated with the correct end date submitted by the issuer on the Enrollment Dispute Form.
- Issuers should monitor the Pre-Audit File to ensure the correct Exchange Assigned Policy ID is being used for an Enrollment Group.

Issuers can find additional information on submitting changes impacting the Exchange Assigned Policy ID on their RCNI by reviewing the Enrollment Reconciliation Education Suite located at https://zone.cms.gov/document/enrollment-data-reconciliation.

Example 6K: An issuer effectuates an enrollee's coverage for January 1 in a QHP and is applying APTC. The enrollee's full premium amount is $400, but after the application of $300 in APTC, the enrollee's member-responsible portion of premium is $100. The enrollee makes all payments fully until they fail to pay the July premium, due July 1. The enrollee enters into the three-consecutive-month grace period on July 1, and the grace period expires September 30. On July 15, the enrollee loses APTC (effective on August 1), due to the expiration of a data matching inconsistency (DMI) period; however, consistent with regulation, since the enrollee's delinquency began while receiving APTC, the enrollee's original three-month grace period continues. On August 10, the enrollee is determined eligible for an SEP but does not utilize the SEP until October 1. On that date, the former enrollee selects the same QHP under which the former enrollee's coverage was terminated effective July 31 and is provided an effective date of November 1. The former enrollee makes a timely and sufficient binder payment. The QHP issuer must effectuate the new coverage because the SEP effective date, November 1, is after September 30, when the grace period ended. The issuer should follow the instructions for submitting an ER&R dispute to establish a new Exchange Assigned Policy ID for policies eligible for a gap in coverage.

Example 6L: Same facts as Example 6K, but here the enrollee is determined newly eligible for APTC (Financial Change SEP) on August 10 and utilizes the SEP to enroll in a plan in a different product, but with the same issuer (this is sent TERMCIC rather than M834 because the QHP ID has changed). The active selection of a QHP in a different product makes this a new issuance subject to a binder payment requirement. The enrollee makes a timely and sufficient binder payment on August 25. The QHP issuer must effectuate the new coverage because the enrollee actively selected a plan in a new product, which is not considered by the FFE to be a continuous enrollment and thus the issuer must collect a binder payment to effectuate the enrollment.

6.5 Grace Periods for Enrollees Receiving APTC

The regulation at 45 CFR 156.270(d) requires issuers to provide a grace period of three consecutive months for an enrollee who, when failing to timely pay premiums, is receiving APTC. During the grace period, the QHP issuer must 1) pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; 2) notify the Department of Health & Human Services (HHS) of such non-payment;[68] and 3) notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.

[68] Issuers notify HHS of nonpayment through the EDA process.

6.5.1 Claims Pended by an Issuer During a Three-Consecutive-Month Grace Period for Enrollees Receiving APTC

Under 45 CFR 156.270(d)(1), issuers may pend claims for services rendered, if permitted by state law, for enrollees receiving APTC who are within the second or third months of the three-consecutive-month grace period. If the enrollee is enrolled in both a QHP and a QDP, is receiving APTC 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 retroactively to the last day of the first month of grace, the issuer may deny any claims that were pended for services received 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 based on the termination of coverage. Any premium collected by the issuer for coverage beyond the designated retroactive termination date should be refunded to the enrollee whose coverage was terminated, in accordance with applicable state law.

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 APTC. 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 Periods Ending After the End of the Annual OEP

The grace period for non-payment of premiums could extend past the end of the annual OEP if enrollees who are receiving APTC fail to pay their premium timely in full or in an amount necessary to satisfy a payment threshold, if applicable, for October, November, December, or January coverage.

If the enrollees' coverage is still in effect at the time of auto-renewal (typically October) and the enrollees have not taken action to actively select a QHP for future year coverage, the FFE generally automatically sends the 834 renewal transaction to the enrollees' QHPs. If the FFE sends an auto re-enrollment transaction (even if the re-enrollment plan is offered under a different product), or if enrollees actively complete a plan selection to renew enrollment through the Exchange in a plan offered under the same product as their re-enrollment plan (where the product under which the QHP in which they are enrolled is not available through the individual market Exchange for renewal, this includes a plan under a different product offered by the same QHP issuer, to the extent permitted by applicable state law),[69] 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 plan selections that are continuations of the same

[69] Pursuant to the Affordable Care Act (ACA); 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 an Exchange (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 re-enrolled in a QHP under a different product pursuant to 45 CFR 155.335(j)(2), that re-enrollment 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.

coverage, as previously described in **Section 6.4.3**, **Prohibition of Option to Condition New Enrollment on Payment of Past-Due Premium**, the issuer may attribute enrollee payments to the oldest outstanding debt in the existing grace period for the current coverage.

However, consistent with 45 CFR 156.270 and 155.430, if the enrollee does not pay all outstanding premiums, or an amount within the tolerance of any applicable premium payment threshold, 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. If the coverage in the new plan year resulted from a renewal of the terminated coverage and is considered a continuation of the current coverage, renewal coverage that is still in passive status (enrollments sent through auto re-enrollment that still have a policy status of 11) will be cancelled by the FFE (typically within a month of receiving the prior-year termination from the issuer) because nonpayment of premium is an exception to guaranteed renewal; the enrollee will be unable to enroll in coverage for the new plan year outside the OEP unless the enrollee is eligible for an SEP. Active enrollments during OEP that result in coverage that is not considered a continuation of the same coverage are governed by guaranteed availability rules, and so some active re-enrollments that would otherwise be cancelled if they were passive re-enrollments must be effectuated by the issuer, subject to payment of the required binder payment.

6.5.2.1 Examples

Example 6M: An enrollee receiving APTC entered a grace period in September and did not pay all outstanding premium due by November 30, and coverage is terminated effective September 30. During the OEP the enrollee actively selects the same plan effective January 1, which the issuer receives as an M834 transaction because the active re-enrollment is an update to the auto re-enrollment sent to the issuer in October. The issuer must accept the January 1 enrollment subject to the requirement to pay a binder payment.

Example 6N: Same facts as Example 6M, except that the enrollee entered the APTC grace period in November and did not pay all outstanding premium by January 31, and thus the coverage is terminated November 30 by the issuer for nonpayment of premiums. During the OEP, the enrollee actively selects the renewal plan effective January 1. While the FFE will not automatically cancel the enrollment because it is in active (not passive) status, the issuer may send a separate cancel transaction for the January 1 coverage because the renewal was an update to a continuous enrollment being terminated (January 1 is not more than one day later than the grace period end of January 31).

Example 6O: An enrollee, who receives APTC, is enrolled in a QHP. The QHP issuer does not utilize a premium payment threshold policy. The enrollee has paid premiums in full throughout the year but fails to pay the December premium by the December 1 due date and enters a three-consecutive-month grace period that would end on the last day of February. The enrollee does not actively select a plan for the new plan year, and the FFE sends an auto-renewal transaction. The QHP issuer must accept the enrollment. The renewed coverage continues into the new plan year, subject to the existing grace period. The enrollee does not pay all outstanding premiums by February, and the QHP issuer retroactively terminates the enrollee's coverage effective December 31 of the prior year. The individual is no longer covered for the new plan year, which the FFE's record will reflect once the Exchange has cancelled the auto-renewal. Since the annual OEP has ended, the individual cannot enroll through the Exchange until the next annual OEP, unless the individual qualifies for an SEP.

Example 6P: Same facts as Example 6O, except the enrollee fails to pay the November premium by the November 1 due date and enters a three-consecutive-month grace period that would end on the last

day of January. During the OEP, on December 4, the enrollee logs into HealthCare.gov, updates their application for the upcoming plan year, and is determined eligible for coverage. The enrollee actively renews the same coverage for January 1 and pays the first month's premium by the due date. Because the enrollee decided to renew their coverage in the same product, which is considered a renewal, 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 renew the enrollment. However, if the enrollee does not pay all outstanding premiums by January 31, the QHP must retroactively terminate the enrollee's coverage effective November 30. The enrollee would no longer be covered for the new plan year, and the QHP issuer must send the FFE a termination transaction for the prior-year plan effective November 30. The FFE will cancel the new plan year auto-renewal within weeks if it is still in passive status, or alternatively, the issuer may send a cancellation transaction for the enrollment.

Example 6Q: An enrollee receiving APTC entered a grace period in October and did not pay all outstanding premium due by December 31, and coverage is terminated effective October 31. On December 2 (during the OEP) the enrollee actively selected the same plan for a January 1 effective date, which the issuer receives as an M834 transaction because the active re-enrollment is an update to the auto re-enrollment sent to the issuer in October. The issuer must accept the January 1 enrollment subject to the requirement to pay a binder payment, and if the issuer effectuates the new enrollment will need to submit a dispute to establish the gap in coverage and receive a new FFE Policy ID for the January 1 policy.

Example 6R: An enrollee receiving APTC entered a grace period in December and did not pay all outstanding premium due by February 28, and coverage was terminated effective December 31. On December 1 (during the OEP) the enrollee actively selected the same plan for a January 1 effective date. While the FFE will not automatically cancel the enrollment because it is in active status, the issuer may send a separate cancel transaction for the January 1 coverage because the selection of the same plan was an update to a continuous enrollment being terminated (January 1 is not later than the grace period end of February 28).

6.5.3 Grace Periods Ending on or Before December 31

When an enrollee with a grace period expiring on or before December 31 actively reselects coverage offered by the same issuer during an OEP with a January 1 effective date, the issuer will generally need to treat the active re-enrollment under guaranteed availability rules, effectuating the new coverage, subject to the requirement to pay a binder payment. This is because the new coverage's start date is after the end of the grace period for the previous coverage, making it a new issuance rather than an update to a terminated policy that can be disregarded. Re-enrollments still in passive status (policy origin 11), however, may be cancelled since eligibility for auto-renewal ends if the associated prior-year enrollment subsequently terminates.

6.5.3.1 Examples

Example 6S: An enrollee enters APTC grace in September for failing to pay the $50 premium. The FFE sends the issuer an auto-renewal in October, which the issuer must process as the enrollee's coverage is still in a grace period. The enrollee makes no more payment on the current-year coverage by the November 30 end of the grace period, so the issuer sends the FFE a termination effective September 30 in early December on the current-year coverage. However, on November 15, the enrollee actively re-enrolled in coverage offered by the issuer under the same product, indicated on a

M834 transaction updating the auto re-enrollment, making it an active re-enrollment (policy origin ≠ 11) subject to guaranteed availability requirements.

The binder on the new coverage is $100. The enrollee pays the issuer $100 by the new coverage binder due date, which the issuer has set as January 1. Although the enrollee has not paid the past-due premium owed to the issuer, the issuer must still effectuate the coverage.

Example 6T: Same facts as Example 6S, except the enrollee never actively re-enrolls, leaving the re-enrollment in passive (policy origin 11) status. The issuer terminates the current-year policy effective September 30 and may cancel the passive re-enrollment or wait for the FFE to carry the current-year termination forward to cancel the future year enrollment.

6.5.4 Termination Occurring During a Grace Period

45 CFR 155.430 allows an enrollee to voluntarily terminate their coverage by notifying the Exchange. If an enrollee seeks to voluntarily terminate coverage while they are 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, or an amount within the tolerance of any applicable premium payment threshold, before the end of the applicable grace period.

6.5.4.1 Examples

Example 6U: An enrollee, who is enrolled in a QHP with an issuer that does not utilize a premium payment threshold, is receiving APTC and enters a grace period on August 1, due to their non-payment of premiums. The grace period extends until October 31, and if the enrollee does not pay their outstanding premiums in full by that date, their coverage will terminate effective August 31, the last day of the first month of the grace period for enrollees receiving APTC. In September, the enrollee contacts the FFE to voluntarily terminate their coverage September 30 because the enrollee will enroll in employer coverage effective October 1. The FFE sends an 834 transaction to the issuer with a termination effective date of September 30. The enrollee makes no further payments to the issuer. By the end of their grace period (October 31), they have not paid all outstanding premiums to the issuer. On November 1, the issuer uses EDA to change the enrollee's effective date of termination to the date of involuntary termination for non-payment of premiums, August 31. The issuer can reject any claims arising from medical service provided after August 31 and must return any APTC paid on the enrollee's behalf for the period after August 31 in accordance with applicable state law.

Example 6V: Same facts as in Example 6U, except that the enrollee contacts the FFE to voluntarily terminate their coverage effective August 15. The FFE sends an 834 transaction to the issuer with a termination effective date of August 15, and the enrollee makes no further payments to the issuer. Because August 15 is earlier than the date the enrollee's coverage would have terminated for non-payment if the grace period had continued (August 31, the last day of the first month of the grace period), the grace period (and the enrollee's coverage) ends on August 15. The enrollee continues to owe the pro-rated premium for August, which the issuer may attempt to collect.

Example 6W: An enrollee, who does not receive APTC, enters a grace period for non-payment of premium on August 1. 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, or an amount within the tolerance of any applicable premium payment threshold, during that one-month grace period, the issuer

may terminate their coverage effective July 31, the last day the enrollee's account was in good standing. In August, the enrollee accesses the FFE to voluntarily terminate their coverage, effective August 24, and the FFE sends an 834 transaction to the issuer with a termination date of August 24. On the last day of the enrollee's grace period, August 31, they have not paid the outstanding premium owed to the issuer. On September 1, the issuer uses the Enrollment Data Reconciliation process to change the enrollee's termination date to July 31.

Example 6X: An enrollee who was receiving APTC failed to make their August premium payment by the issuer's set deadline, triggering a grace period that began on August 1. On August 31, the enrollee submitted a payment of $900, satisfying both their August and September premiums and exiting the grace period. On September 1, the issuer received a HICS case communicating the enrollee's request for a retroactive termination of coverage effective July 31. The enrollee also terminated their coverage prospectively beginning on September 1. Because the HICS case narrative did not contain a valid reason for retroactive termination, the issuer denied the request consistent with CMS policy. The issuer then refunded the enrollee's pro-rated premium for the remainder of September, in accordance with state law. On October 3, the enrollee reversed the August 31 payment through their bank, resulting in a debt for August and September's premium. In this situation, the issuer cannot retroactively terminate the enrollee's coverage due to nonpayment for August, since the enrollee's coverage has already been terminated, and the issuer cannot place the enrollee in a grace period. However, the issuer is entitled to attempt to collect the outstanding premium debt owed by the enrollee.

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

An enrollee who receives coverage during a citizenship/immigration status inconsistency period, and who does not pay monthly premiums timely, 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 Exchange coverage or enrollment 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. Note that lack of lawful presence is not an exception to guaranteed renewal, and the terminated enrollee may be eligible to continue coverage outside the Exchange.

6.5.5.1 Examples

Example 6Y: An enrollee, who receives APTC, is in a citizenship/immigration status inconsistency period that expires June 30, unless it is resolved earlier. The enrollee is also in a grace period ending on June 30, because they did not pay their April premium in full. As of June 30, the enrollee's inconsistency has not been resolved. Additionally, as of June 30, the enrollee has not paid the outstanding premium, and their coverage terminates effective April 30, per 45 CFR 155.430 and 45 CFR 156.270. The termination for non-payment retroactive to April 30 applies.

6.5.6 Removal of APTC During a Grace Period

If an enrollee receives APTC and is delinquent on premium payments, the enrollee will receive a three-consecutive-month grace period, pursuant to 45 CFR 156.270(d). If such an enrollee becomes ineligible for APTC during the three-consecutive-month grace period, the APTC will terminate according to normal Exchange operations, but the enrollee will have until the end of the three-consecutive-month grace period to pay all outstanding premium or an amount within the tolerance of any applicable premium payment threshold. If the enrollee does not make sufficient payment to avoid

termination for non-payment, the enrollee's termination date would adhere to the rules for an APTC grace period stated in 45 CFR 155.430(d)(4).

6.5.6.1 Examples

Example 6Z: An enrollee, who is receiving APTC and is subject to an annual household income inconsistency, enters a grace period on August 1 due to their non-payment of premium. The grace period extends until October 31. On August 31, the enrollee's income inconsistency expires and the APTC is adjusted to $0 by the FFE. Although the FFE will end the enrollee's APTC effective September 1, the enrollee will have until October 31 to make full payment of all outstanding premium to avoid their coverage being terminated effective August 31, the last day of the first month of the grace period.

Example 6AA: An issuer effectuates an enrollee's coverage for January 1 in a QHP and is applying APTC. The enrollee's full premium amount is $400, but after the application of $300 in APTC, the enrollee's member-responsible portion of premium is $100. The enrollee makes all payments fully until they fail to pay the July premium, due July 1. The enrollee enters into the three-consecutive-month grace period on July 1, and the grace period expires September 30. On July 15, the enrollee loses APTC (effective on August 1) due to the expiration of a DMI period; however, consistent with regulation, since the enrollee's delinquency began while receiving APTC, the enrollee's original three-month grace period continues. After receiving a bill for August coverage ($400), which reflects the change in APTC, the enrollee returns to the FFE on August 10, is determined newly eligible for APTC (effective on September 1), and utilizes the SEP under 45 CFR 155.420(d)(6) to maintain enrollment in the same plan. The enrollee pays the QHP issuer $100 on August 15 but makes no further premium payment. The enrollee's coverage is terminated by the QHP after the APTC grace period expires, with a termination effective date of July 31. Since the Financial Change SEP M834 transaction restarting APTC for the enrollee effective September 1 updated the original coverage effective date during the applicable grace period without a gap between the current coverage and the effectiveness of the change, the M834 transaction effective September 1 is considered to be part of one continuous enrollment, extending from January 1 through July 31, rather than one enrollment starting on January 1 through July 31 and a second, new enrollment starting on September 1 (there was no gap in coverage before the September 1 effective date of the M834 transaction because the policy was still in the grace period on September 1). Therefore, the QHP issuer must terminate the enrollee's coverage on July 31 for non-payment of premium.

Example 6BB: An enrollee is re-enrolled in coverage with a premium of $500, for which the member-responsible portion of premium is $100 after the application of APTC. The enrollee pays the $100 owed for January through March but fails to pay April's premium. As a result, the issuer places the enrollee in a three-month grace period that begins April 1, and the enrollee has until June 30 to pay all outstanding premiums and avoid termination of coverage. In March, the enrollee updates their application to reflect an increase in income and becomes ineligible for APTC starting April 1. However, in May, the enrollee updates their application again to reflect a decrease in income and becomes eligible for APTC again effective June 1. On April 15, the enrollee pays the past-due premium for March, as well as the full gross premium for April, but does not pay the premium for May by the issuer's deadline of May 31. Because the enrollee did not pay all past-due premium by the end of the grace period, the issuer retroactively terminates the enrollee's coverage effective April 30.

6.5.7 Processing Fees and Premium Payments

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 applicable 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 individuals may make in-person payments to vendors who will deliver their payment to a utility or other creditor and require the individual to pay any processing or transaction fee directly to the third party before the third party transmits the payment to the ultimate recipient. CMS encourages issuers to require that processing fees be delineated separately from the premium payment on any receipt or other evidence of the transaction.

6.6 Over-Billed Premiums

QHP and QDP issuers may correct any over-billed premium amount, which is when an issuer bills an enrollee or enrollees for an erroneously high premium amount, according to their own policies and consistent with applicable state law. Issuers should, 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.

A QHP issuer that receives notice from the Exchange that an individual enrolled in the issuer's QHP is eligible for an APTC must:

1. Reduce the portion of the premium charged to or for the individual for the applicable month(s) by the amount of the APTC.
2. Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with 45 CFR 156.265(g).
3. Include with each billing statement, as applicable, to or for the individual the amount of the APTC for the applicable month(s) and the remaining premium owed.

Any resulting APTC discrepancies would be addressed during the Enrollment Data Reconciliation process.

6.7 Under-Billed Premiums

6.7.1 Overview

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). Issuers of QHPs in states where CMS directly enforces the ACA market reforms that discover an under-billing error impacting two or more policies, should inform their CMS Account Manager of the discovery. In such states, CMS will consider exercising enforcement discretion to allow issuers to forego collection of under-billed premiums on a case-by-case basis, and issuers must obtain permission from CMS (by consulting with their Account Manager) prior to foregoing collection of premiums in these direct enforcement states.

In states that have retained primary enforcement authority of the ACA market reforms (and for which CMS has not determined that the state is failing to substantially enforce the applicable requirement), CMS generally defers to the relevant state authority. Therefore, in those states, QHP issuers must consult the relevant state authority to obtain permission to forego the collection of any under-billed portions of premiums and should communicate that permission to their Account Manager. Such action alone does 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 with express permission from CMS (direct enforcement states) or at the direction of the applicable state authority (state enforcement states), the issuer must characterize the uncollected premiums as realized/earned premium for purposes of medical loss ratio (MLR) and risk adjustment (RA) data submission. If the issuer does not obtain permission from the relevant Federal or state authority to forgo collection of premiums, the issuer must attempt to collect the remaining balance of unpaid premium, consistent with the guidance in **Section 6.7.2**, **Collections and Grace Periods for Non-Payment of Under-Billed Premium**. CMS also expects issuers to maintain applicable documentation of the CMS or state permission, and SOPs demonstrating that the permission to forego collection of premiums was applied uniformly.

6.7.1.1 Examples

Example 6CC: On December 5, Enrollee A completes an application for enrollment through the FFE, makes a plan selection, and enrolls in a QHP with an effective date of January 1. Enrollee A pays their first month's premium on time, and the enrollee's coverage is effectuated for January 1. Enrollees B and C (who live in the same state as Enrollee A) complete applications for enrollment through the same FFE, make plan selections, and enroll in the same QHP as Enrollee A with an effective date of January 1. Enrollees B and C pay their first month's premium on time, and the enrollees' coverage is effectuated for January 1. The issuer bills all three enrollees for premiums in February and March, which they pay in full. While generating the April billing invoices, the issuer's billing system malfunctions, causing the issuer to bill Enrollee A for April's premium while failing to bill Enrollees B and C. Enrollee A pays their premium for April coverage, but Enrollees B and C do not, since they did not receive a bill. The next month, the same malfunction occurs; Enrollee A pays the May premium and Enrollees B and C do not. The issuer realizes the billing problem while generating invoices for June. The enrollees reside in state Z, which has retained primary enforcement authority. The issuer informs their CMS Account Manager of the under-billing error. The issuer requests and receives permission from the state Z Department of Insurance to forego collection of Enrollees B and C's under-billed premium and communicates that permission to their Account Manager. As long as this permission is documented and the policy is applied consistently and in a non-discriminatory manner, the issuer can forego collection of the under-billed premium related to Enrollees B' and C's accounts, but must report such uncollected premium to CMS as being earned/realized income for purposes of MLR and RA.

Example 6DD: Same facts as in Example 6CC, except that the enrollees live in a state where CMS directly enforces the market reforms. In addition to contacting the state Z Department of Insurance, the issuer informs their CMS Account Manager, who reaches out to the appropriate CMS staff to inform them of the issuer's request to forgo collection of premiums for enrollees B and C. CMS approves the issuer's request, and the issuer can forego collection of the under-billed premium as long as this permission is applied consistently and in a non-discriminatory manner. The issuer must also report the uncollected premium to CMS as being earned/realized income for purposes of MLR and RA and must maintain documentation of the permission obtained from CMS.

6.7.2 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 enrollee's regularly billed monthly premium amounts. However, CMS expects issuers to correct billing to reflect additional under-billed premium amounts within the same billing cycle that the error is identified. 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 they do not pay all under-billed premium installments (as well as all regularly-billed monthly premiums) by the prescribed due dates, they will enter the applicable grace period. Issuers are expected to maintain evidence of this payment plan for under-billed premiums for 10 years (45 CFR 156.705). CMS expects issuers to maintain applicable documentation of the state's decision, and SOPs demonstrating that payment plans were applied uniformly.

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, they enter 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 can become due, if permitted by state law. This also applies to scenarios in which an issuer reinstates coverage that was erroneously terminated, and the issuer must bill the enrollee for the reinstated and previously under-billed months of coverage. If the enrollee fails to pay the under-billed premium that is added to the next month's premium bill, the issuer must place the enrollee in a grace period (either the three-month grace period for enrollees receiving APTC or a state grace period if applicable), and the issuer must terminate coverage if the enrollee fails to pay all outstanding premiums (or an amount that is sufficient to satisfy the issuer's premium payment threshold) by the end of the grace period. Issuers that forego the collection of under-billed premium should follow the guidance in **Section 6.7.1**, **Overview**.[70]

Note on Under-Billed Premium and Grace Periods: Grace periods must always be prospective, and an enrollee can only be placed in grace if they fail to pay the full amount (or the amount within a premium threshold, if applicable) that they are billed by an issuer by the due date. Enrollees cannot be placed into grace periods that are retroactive based on the fact that the issuer failed to bill the enrollee the correct amount of premium for a past month. For example, if an issuer discovers in May that it billed an enrollee an erroneously low amount of premium for January-April, the issuer **cannot** retroactively terminate the enrollee's coverage effective January 31, on the assumption that their grace period ran from January-March. Instead, following the guidance in this section, the issuer in this example should add the under-billed amount to the June premium bill (or a future bill), and place the

[70] During CMS's issuer enrollment policy audit process, issuers who did not collect under-billed premium from impacted enrollee(s) are expected to provide evidence of state Department of Insurance (or similar regulatory body) or CMS permission to forgo collection of premiums, or records of any applicable state laws permitting issuers to waive the collection of under-billed premium, and internal SOP documentation that the policy was applied uniformly.

enrollee in a grace period only if they fail to pay the full amount of that monthly bill (or an amount within the issuer's premium threshold).

6.7.2.1 Examples

Example 6EE: Enrollee A lives in state Y, which has retained primary enforcement authority of the ACA market reforms. On December 5, Enrollee A completes an application for enrollment through the FFE, makes a plan selection, and enrolls and effectuates coverage in a QHP with an effective date of January 1 and a premium of $400. The enrollee is eligible for and elects to receive APTC, applying $300 APTC to premium, leaving them responsible for $100/month. The issuer's premium due date is the first of each month. Enrollee A reports a change in income that makes them ineligible to receive APTC beginning in April. While generating the April premium bill, the issuer's billing system malfunctions, causing the issuer to fail to correct Enrollee A's bill to reflect the full premium due, without APTC. The same malfunction occurs during the generation of the May and June premium invoices, meaning the enrollee was under-billed $900 ($300 each for April, May, and June). The issuer discovers the under-billing error in time to correct the July bill and properly informs its applicable state authority and consults CMS by contacting its CMS Account Manager.

State Y directs the issuer to recoup the enrollee's under-billed premiums, starting with the April payment. The issuer allows the enrollee six months to repay the under-billed premiums, billing the enrollee an extra $150 for July – December, meaning the enrollee must pay $550 each month to maintain good standing ($400 regular premium, plus $150 under-billed premium installment). Enrollee A pays only $400 of their $550 July premium and thus becomes delinquent. Because they are no longer receiving APTC, their grace period is determined by state Y, which has a one-month grace period that begins on July 1, the date they entered delinquency. If they fail to pay all their premium due (within the payment threshold, if applicable) by July 31, the issuer must terminate their coverage due to non-payment back to June 30, the last day of good standing pursuant to state Y's grace period policy, which is the last day of the month before the enrollee's grace period started.

Example 6FF: Same facts as Example 6EE, except the enrollee is not eligible for APTC as of July 1. Without APTC, the enrollee's monthly premium is $200. The enrollee pays $280 for July coverage but pays only $200 for August coverage. Pursuant to state X's rules, because the enrollee underpaid by $80 for August, they enter into a one-month grace period and termination of their coverage for non-payment of premiums would be retroactive to the last day their account was in good standing (July 31 in this example). To avoid termination of their 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, and the issuer begins normal monthly premium billing for September.

Example 6GG: On December 5, an enrollee completes an application for enrollment through the FFE, makes a plan selection, and enrolls in a QHP, whose issuer does not utilize a premium payment threshold, with an effective date of January 1. The enrollee is eligible for and elects to receive APTC, and the portion of the monthly premium for which they are responsible is $100. The enrollee timely pays the first month's premium, and coverage is effectuated for January 1. The issuer bills the enrollee normally for coverage in February. The enrollee pays their $100 monthly premium in full. While generating the invoices for March, the issuer realizes that the enrollee's premium has been rated incorrectly and that the proper monthly premium is $120. The enrollee's new premium goes into effect with QHP A's March 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

March billing, allows the enrollee 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.

While the enrollee may be eligible for an SEP based on the error, they decide to remain enrolled in the same QHP. The enrollee sends the issuer $120 for March coverage but does not include a $20 under-billed premium installment. Although the enrollee paid the new regular monthly premium for March ($120), the enrollee did not pay the first under-billed premium installment. They enter into a three-consecutive-month grace period on March 1 and must pay all additional regular monthly premium billed during the grace period ($120 for April and $120 for May), 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 they 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 (March 31), for non-payment of premiums. The issuer will receive the enrollee's APTC for March, and it may retain the premium the enrollee paid for March, but it must return the APTC paid on their behalf for April and May and refund the enrollee the premium they paid for April and May ($240).

Example 6HH: Same facts as Example 6GG, except the enrollee is not eligible for APTC as of March 1. Here, the enrollee's monthly premium is $200. If the enrollee pays only $200 for May coverage, failing to include $20 for the under-billed premium installment, the enrollee enters a one-month grace period, starting on March 1, as determined by the rules of the enrollee's state. They must pay the amount of outstanding under-billed premium ($40) before the expiration of the grace period to avoid termination of their coverage. During the grace period, the enrollee makes no further payments. Although the enrollee paid the regular monthly premium of $200 for March, 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 their coverage, retroactive to February 28, the last date that the enrollee was in good standing.

Example 6II: Same facts as Example 6GG, except that rather than allowing the enrollee to pay two monthly installments of $20 in addition to the corrected premium payments, the issuer requires the enrollee to pay the full $40 up-front. Accordingly, the issuer bills the enrollee $160 for March, which includes $120 for March's premium and the under-billed $40 from January and February. The enrollee only sends the issuer $120 for March, and because the enrollee did not pay the full amount owed ($160), the issuer places the enrollee in a grace period starting March 1. The issuer continues to bill the enrollee for April and May but does not receive any further premium payments by May 31. As a result, the issuer terminates the enrollee's coverage effective March 31. The issuer must return the APTC received for April and May and may continue to attempt to collect the remaining $160 owed by the enrollee.

Example 6JJ: A consumer enrolls in coverage effective January 1 and pays their binder payment by the issuer's deadline. The enrollee also pays February's premium by the deadline. However, on February 28, the enrollee's coverage is erroneously terminated by their issuer, who did not record the enrollee's February payment due to a system error. The issuer discovers this error in June and contacts the enrollee to give them the option of reinstatement retroactive to February 1, or prospective coverage beginning July 1.[71] The enrollee requests reinstatement of coverage and is billed for the four preceding

[71] In accordance with 45 CFR 155.420(b)(2)(iii) and (d)(5). See **Exhibit 15** in **Section 5.6.1**, **Coverage Effective Dates**.

months of retroactive coverage (March-June, plus July's premium) during the July billing period. The enrollee does not pay the full amount by the issuer's deadline, so the issuer places the enrollee in a grace period beginning July 1 and running through September 30. The enrollee does not make any further premium payments prior to September 30. Therefore, the issuer terminates the enrollee's coverage effective July 31, the first month of the grace period.

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

If an enrollee voluntarily terminates their coverage during the time they are 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.

6.7.3.1 Examples

Example 6KK: On December 5, an enrollee completes an application for enrollment through the FFE, makes a plan selection, and enrolls in a QHP with an effective date of January 1. The enrollee is eligible for and elects to receive APTC, and the portion of the monthly premiums for which they are responsible is $100. The enrollee pays their first month's premium, and coverage is effectuated for January 1. While generating the March 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 premium, since they did not receive a bill. The same malfunction occurs in April, May, June, July, and August; the enrollee does not pay the monthly premiums for any of those months. The issuer uncovers the billing problem while generating invoices for September. The enrollee, who is a resident of state W, owes the issuer $600 of under-billed premiums in addition to their normal monthly premium payments of $100. State W instructs the issuer to recoup the under-billed premiums, beginning with the September billing cycle. The issuer allows the enrollee three consecutive months to repay the under-billed premiums. The issuer informs the enrollee that it will bill the enrollee $300 (normal monthly premium of $100 plus an under-billed premium installment payment of $200) for September, October, and November coverage. The enrollee pays the issuer $300 for coverage in September. On September 14, the enrollee informs the issuer that they wish to terminate coverage effective September 30. 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, the date the voluntary termination will take effect. The enrollee receives the accelerated repayment schedule and pays the outstanding under-billed premiums.

Example 6LL: Same facts as Example 6KK, but when the issuer bills the enrollee $400 for the under-billed premiums, due on September 30, 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 Payment Redirect

For the initial enrollment with an issuer, once a QI confirms plan selection at HealthCare.gov, the FFE enables redirection of the QI from HealthCare.gov to the issuer's payment site only if the QI is eligible for payment redirect. For a QI to be eligible for payment redirect, the following criteria must be met:

- The issuer has submitted a valid payment site in its QHP application to HIOS SSM.

- The QI's policy is active and has not already been effectuated.
  NOTE: If the consumer receives a Pended Plan Selection (PPS) due to an SEP Verification Issue (SVI), the consumer will not be eligible for payment redirect until the SVI has been resolved and the PPS has been released to the issuer.
- The consumer's coverage effective date is in the future.
  NOTE: After the effective date of the policy, the consumer will not be eligible for payment redirect. For example, if a new policy is created with a newborn SEP, and the effective date is retroactive, the consumer will not be eligible for payment redirect.
- For dental plans only, a consumer will only be able to complete the payment redirect if the dental policy has a guaranteed premium.
  NOTE: If a dental policy has an estimated premium, the consumer will not be eligible for payment redirect.

If the QI selects plans from more than one issuer, the FFE enables multiple payment redirects, with each redirect occurring in a separate window. Payment redirect typically occurs before the FFE generates the 834 enrollment transaction to the QHP issuer. Therefore, at the time of payment redirect, the QHP issuer often does not have any information on file regarding a QI's plan selection and, if eligible, the APTC amount selected. To address this, the FFE electronically securely transfers basic information in the redirection to the issuer's payment portal so the QHP issuer can accept payment. Information sent in the payment redirect generally includes subscriber information, plan selection, the QI's portion of premium due, and the amount of APTC applied to the premium.[72]

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 effectuation of enrollments. If a QHP issuer is not capable of accepting online payment at the time of redirect, or elects not to do so, CMS provides standard language to QIs that the issuer will bill them for premium payment.

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). Since 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 FFE, 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.

6.9 Premium Payment Methods

QHP issuers are required to accept paper checks, cashier's checks, money orders, EFTs, and all general-purpose prepaid debit cards[73] as methods of payment. Further, according to 45 CFR

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

[73] General-purpose prepaid debit cards include those issued by state agencies for the purpose of paying for benefits, including healthcare.

156.1240(a)(2), the QHP issuer must present all payment method options equally for a QI to select the preferred payment method.

In accordance with 45 CFR 156.1240(a)(3), issuers must also accept premium payments made by or on behalf of an enrollee from an individual coverage Health Reimbursement Arrangement (ICHRA) or qualified small employer HRA (QSEHRA) in which the enrollee is enrolled.

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 QIs who elect a specific type of premium payment method (e.g., EFT). Additionally, issuers may not apply additional fees to QIs 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.

6.10 Payment of Premium by a Third Party

Under 45 CFR 156.1250, issuers offering individual market QHPs, including QDPs, and their downstream entities, must accept premium and cost-sharing payments on behalf of plan enrollees from the following third-party entities (in the case of a downstream entity, to the extent the entity routinely collects premiums or cost-sharing):

1. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act
2. An Indian tribe, tribal organization, or urban Indian organization
3. A local, state, or Federal government program, including a grantee directed by a government program to make payments on its behalf

If an enrollee or third-party entity 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. If a third-party entity provides notification, the issuer should continue to allow for timely premium payment to prevent termination of enrollments for non-payment.

6.11 Enforcement Discretion Regarding FEMA-Designated Natural Disasters

If issuers comply with any state regulatory authority's request to extend payment deadlines and delay cancellations for non-payment of premium in reaction to a natural disaster or other emergency disruption within a state, CMS may exercise enforcement discretion with regard to regulatory requirements such as the deadline for payment to effectuate coverage and the deadline for payment of premiums under grace periods, including for individuals receiving APTC. For future APTC audits, CMS expects issuers to maintain applicable documentation of the state regulatory flexibility for at least 10 years and SOPs demonstrating this flexibility was applied uniformly. Information about PBP audits can be found in **Section 18**, **Policy-Based Payment Two-Phase Audit Approach Overview**.

7. TERMINATIONS (APPLICABLE TO THE INDIVIDUAL MARKET FFE, SBE-FPS, QHPS/QDPS)

7.1 Introduction

A termination is the end of an enrollee's coverage or enrollment in a Qualified Health Plan (QHP) or Qualified Dental Plan (QDP) through an Exchange occurring after their coverage effective date. A termination may be either voluntary (i.e., initiated by the enrollee) or involuntary (i.e., initiated by the QHP/QDP or the Federally-facilitated Exchange (FFE). Issuers must notify the Exchange of involuntary terminations. If an enrollee's coverage or enrollment through an Exchange is terminated, the QHP or QDP must provide coverage from the coverage effective date through the termination date.

The QHP/QDP issuer, or the FFE, can initiate an involuntary termination of an enrollee's coverage or enrollment through the FFE. 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 Exchange in the initial QHP/QDP is effective the day before coverage in a different QHP/QDP becomes effective, even in cases of retroactive enrollment.

An Exchange 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 an individual market Exchange. The following are operational standards for the FFE.

Pursuant to 45 CFR 156.270(b)(1), issuers must send termination notices, including the termination effective date and reason for termination, to enrollees for all termination events.

7.2 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 an Exchange. Enrollees in a QHP must request a voluntary termination of their coverage or enrollment through the FFE (either online on HealthCare.gov or a Direct Enrollment [DE] Entity or through the Marketplace Call Center). Enrollees in a QDP, however, may contact the QDP issuer directly to request voluntary termination of their coverage; the QDP issuer then notifies the FFE of the termination using Enrollment Data Alignment (EDA). According to 45 CFR 155.430(d)(2), an enrollee who voluntarily terminates coverage or enrollment through the Exchanges, at the option of the Exchange, will be granted same-day or prospective coverage termination dates based on the date of their request. QHP issuers are encouraged to remind enrollees to report voluntary termination requests to the Exchange.

In accordance with 45 CFR 155.430(b)(1)(iv), CMS must provide approval for an enrollee to retroactively terminate or cancel their coverage or enrollment in a QHP/QDP if they experienced an Exchange error or a technical error that did not allow the enrollee to terminate their coverage or enrollment through the Exchange at the time of their request. The requests will be sent to issuers via a Health Insurance Casework System (HICS) case. External comments will be added by a CMS caseworker denoting the approval of the enrollee's request, or if denied consideration for retroactive termination based on polices issuer have purview over (i.e., non-payment of premiums, and free look

provisions). Issuers must initiate a plan request for CMS review if the HICS case in this scenario was misrouted to the issuer initially, prior to CMS reviewing the case.

Refer to **Section 6.5.4**, **Termination Occurring During a Grace Period**, for guidance regarding terminations during a grace period.

7.2.1 Termination Requests Due to an Enrollee's Retroactive Enrollment in Medicare

In the 2025 Notice of Benefit and Payment Parameters, CMS finalized an option at 45 CFR 155.430(b)(1)(iv)(D) for the FFE to permit enrollees to retroactively terminate QHP coverage due to retroactive enrollment in Medicare Parts A or B (including retroactive enrollment in Medicare Advantage). This option was implemented for the FFE in December 2024. QHP enrollees who enroll retroactively in Medicare Parts A or B (such as due to eligibility for Social Security Disability Insurance), including coverage through a Medicare Advantage plan, may request a retroactive termination of QHP coverage to eliminate the overlap between the two. Enrollees will be granted a maximum of six months of retroactive termination from the date the request is made (but no earlier than the date of enrollment in Medicare). Enrollees will have 60 days from the date of enrollment in Medicare to make the request. Requests for retroactive termination must be made through the Marketplace Call Center, where a HICS case will be created and sent to the issuer with comments denoting approval of the enrollee's request if Medicare enrollment is verified.

7.3 Termination of an Enrollee's Coverage in the FFE Due to Report of Death

Enrollees who are enrolled through the FFE 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 FFE conducts redeterminations of eligibility consistent with 45 CFR 155.330 for the remaining members of the household. If a qualified individual (QI) or representative contacts the issuer directly, the issuer should provide the following directions[74]:

- 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. A QI who meets the definition of an application filer, as described in 45 CFR 155.20, is allowed to update the application for the remaining members of the household if the deceased filed the application.
- If the individual reporting the death is not an application filer, they must submit documentation of death to the FFE. Individuals in this circumstance should submit documentation directly to the FFE. 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:

[74] Please note that issuers cannot contact the Marketplace Call Center directly to report an enrollee's death; if an issuer has reason to believe an enrollee is deceased, they should reach out to the estate and encourage them to report the death to the FFE following the process outlined in this section.

- Full name of the deceased
- Date of birth (DOB) of the deceased
- FFE application ID (if known) of the deceased
- Social Security Number (SSN) (if known) of the deceased
- Contact information for the person submitting the documentation, including the following:
  - 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 QI who submits documentation of death regarding the termination of the deceased and re-enrollment 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 FFE applications. These additional changes may qualify the remaining enrollees for a Special Enrollment Period (SEP).

When an enrollee's coverage is being terminated due to death, the issuer receives the appropriate 834 enrollment transaction. The effective date generated by the FFE system will be prospective. The Marketplace Call Center will open a case in the HICS and assign the case to the issuer for retroactive enrollment of the remaining QI so there is no lapse in coverage.

The individual 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.

Example 7A: An enrollee, who is the subscriber in the enrollment group, contacts the FFE on August 7, to report that their spouse died three weeks earlier on July 14. As a result of their spouse's death, the FFE representative informs the QI that they now qualify for an SEP. The FFE confirms the date of death and assigns the issuer a Category 2 (Plan and Issuer Concerns) HICS case requesting a retroactive termination date of July 14 for the coverage of the spouse.

Additional information about terminations due to death is included in **Section 11.6**, **Deceased Enrollee PDM**.

7.3.1 Using the ER&R Process to Terminate Coverage Due to Report of Death

If, after multiple attempts to contact the deceased enrollee's estate, an issuer is unable to use the process described in **Section 7.2**, **Enrollee Requested Terminations**, to have a member of the estate report the death, the issuer may contact their lead caseworker to request the creation of a HICS case. The HICS case must include CMS caseworker approval to remove the member, the deceased enrollee's application ID and FFM Exchange-assigned policy IDs, the date of death, documentation of the death, total premium amount and new subscriber information, if applicable, and an explanation that after repeated attempts to contact the deceased's estate, the deceased enrollee has still not been removed from the policy. The issuer will submit a Plan Request to the Enrollment Resolution and

Reconciliation (ER&R) contractor as a Removal of a Member HICS Direct Dispute. The ER&R contractor will attempt to remove the deceased enrollee from the policy, as ER&R can remove deceased enrollees from both single and multi-person policies.

7.4 Aging-off Terminations

Section 2714 of the Public Health Service Act, implemented at 45 CFR 147.120, states that a group health plan or a health insurance issuer offering group or individual health insurance coverage that makes available dependent coverage of children must make such coverage available for children until the attainment of 26 years of age. A state may not have a rule that conflicts with this standard. Examples of prohibited eligibility criteria for child dependents under the age of 26 include standards related to place of residence, student status, disabled veteran status, marital status, or financial dependence. Some states have more generous rules that require issuers to allow certain individuals to remain covered as child dependents beyond age 26 if additional criteria are met. Additionally, many FFE issuers set maximum child dependent ages above their state minimums. Information on specific states that require issuers to extend the age limit beyond 26 is not included in this manual and must be obtained directly from the state's regulatory authority.

FFE issuers may not terminate coverage during the plan year for an adult child dependent who turns 26 or, if higher, the maximum applicable age under state law or under the plan's business rules, on the basis of the child's age, unless otherwise permitted.[75] If a dependent who reaches the maximum applicable age returns to the FFE during the plan year and updates their application to reflect this change in age, they will have the opportunity to enroll in a separate plan (if eligible for an SEP) or to end coverage. However, if the dependent does not return to the FFE during the plan year or voluntarily terminate their coverage, the issuer must keep them enrolled for the remainder of the plan year.

The FFE will apply the issuers' maximum child dependent age rules, which issuers submit during QHP certification, to determine whether a dependent is eligible to enroll in a parent's coverage when a family actively re-enrolls during the Open Enrollment Period (OEP), during the annual Batch Auto Re-enrollment (BAR) process, or through an SEP. As a result, at the end of the plan year, issuers may renew a family's coverage but must exclude adult child dependents who are age 26 or over (or, if higher, the maximum applicable age under state law or the plan's business rules). The adult child dependent, if eligible, will be automatically enrolled into their own plan (subject to the requirement to pay a binder payment), though they may instead elect to end coverage. Adult child dependents who have aged out of dependent coverage under their parent's plan will generally be eligible for enrollment in a QHP on their own policy and for their portion of the family's advance payments of the premium tax credit (APTC).

7.5 Issuer Termination Notice Requirements

In the 2021 Notice of Benefit and Payment Parameters, CMS finalized a proposal to amend 45 CFR 156.270(b)(1) to require issuers to send termination notices for all termination events described in 45 CFR 155.430(b).

This requirement includes the following scenarios (non-exhaustive):

- Enrollee-initiated terminations

[75] See 45 CFR 155.430(b)(3).

- Issuer-initiated terminations
- Cancellations
- Enrollee fails to pay binder
- Enrollee changes plans within the same issuer
- Enrollee is auto re-enrolled, but changes issuers during open enrollment
- Termination sent by the FFE

Practically, this means that issuers should generally send a termination notice whenever the policy ends or there is a change in the FFE-assigned policy ID in the case of Exchange coverage that continues for some family members albeit with a new subscriber.[76] Termination notices do **not** need to be sent when issuers use the CMS standard renewal or discontinuation notices[77] to explain future coverage at the end of the plan year.

In accordance with 45 CFR 156.270(b)(1), the termination notice must include the effective date and reason for the termination and must be sent "promptly and without undue delay." Although this regulation does not set a specific number of days within which issuers must send termination notices, CMS expects issuers to make every effort to send termination notices as soon as is feasible and may find issuers who unreasonably delay sending termination notices to consumers to be non-compliant (see **Section 18**, **Policy-Based Payment Two-Phase Audit Approach Overview**, for more information on audits).[78] The termination reason may be brief, and issuers can refer to the Maintenance Reason Code (MRC) or Additional MRC (AMRC) on the 834 transaction or HICS directive for information on the termination reason. Issuers should ensure that their use of the terms "termination" and/or "cancellation" in their enrollee notices and communications with CMS align with the definitions specified in 45 CFR 155.430(e). If there is no reason for termination listed, the issuer may simply state that the FFE has terminated coverage. CMS does not provide model termination notices for every scenario, but **Appendix C – Sample Termination Letter** offers a sample termination letter.

7.5.1 Examples

Example 7B: During open enrollment, a consumer selects a QHP with Issuer A on HealthCare.gov. However, they fail to make the binder payment by the deadline established by the issuer, and as a result, their coverage is never effectuated. Issuer A must send the enrollee a termination notice informing the enrollee that their coverage was cancelled effective January 1 due to failure to pay binder.

Example 7C: An enrollee who is enrolled in a policy with Issuer C is auto re-enrolled into a different product effective January 1 through the BAR process and does not return to HealthCare.gov during the OEP to select a different plan. Issuer C sends the required standard re-enrollment notice,[79] which satisfies the obligation at 45 CFR 156.270 to notify the enrollee of the termination of their prior

[76] An exception is situations in which the tobacco rate changes, since X12 rules require a new FFE-assigned policy ID even if a new policy was not issued.

[77] Issuers can review the latest version of the notices under the Health Insurance Market Reforms heading, and the Guidance subheading, at Regulations and Guidance | CMS.

[78] For example, absent extenuating circumstances, CMS would not consider a termination notice sent two months after a termination event to have been sent "promptly and without undue delay."

[79] Issuers can review the latest version of the notices under the Health Insurance Market Reforms heading, and the Guidance subheading, at Regulations and Guidance | CMS.

coverage and notifies them of their re-enrollment in new coverage. Issuer C is not required to send the enrollee a separate termination notice at the end of the plan year.

Example 7D: Same scenario as in Example 7C, except that the enrollee does return to HealthCare.gov in November during the OEP and selects a different plan with Issuer D. Issuer C must send the enrollee a termination notice informing the enrollee that their coverage was terminated effective December 31 because they chose to end it.

8. REINSTATEMENTS (APPLICABLE TO INDIVIDUAL MARKET FFE, QHPS/QDPS)

8.1 Introduction

A reinstatement is the reversal of a termination or cancellation to correct an issuer or Exchange error or reflect an Exchange Appeals decision. A reinstatement results in restoration of an enrollment to the original coverage effective date with no break in coverage. Some common permitted reasons for reinstatements are:

- Erroneous termination or cancellation of an enrollment by an issuer,[80] including terminations for non-payment that were erroneous because the issuer did not comply with the requirements of 45 CFR 156.270(g).
- Erroneous termination or cancellation of an enrollment initiated by an agent or broker (A/B).
- Erroneous termination or cancellation of an enrollment by an enrollee (dental only).
- Erroneous death notification.
- Exchange error/system limitations.
- Assister error.
- Directive to reinstate coverage based on outcome of appeal.

CMS will not permit reinstatements requested for reasons other than Exchange or issuer error, such as:

- An enrollee's failure to pay a binder payment by the issuer's deadline.
- Discretion exercised by an issuer's management
- Non-erroneous issuer policy.

8.1.1 Examples

Example 8A: A consumer is enrolled in a Qualified Health Plan (QHP), without advance payments of the premium tax credit (APTC), effective January 1. They timely pay January and February's premium, but the issuer does not receive March's premium payment by the March 1 deadline. Since there is no state grace period, the issuer terminates the enrollee's coverage effective February 28. On March 10, the enrollee calls the issuer to ask about the reason for cancellation, and states that they did pay March's premium. After reviewing their records, the issuer determines that due to a system error, the enrollee's payment was not reflected on their account balance. The issuer updates their records to reflect March's premium as paid, and because the termination was due to issuer error, the issuer grants the enrollee's request to reinstate coverage effective March 1.

Example 8B: Same facts as Example 8A, except that the enrollee calls the issuer and states that they were unable to pay March's premium because they were travelling outside the country. Since the enrollee's request is not based on issuer or Federally-facilitated Exchange (FFE) error, the issuer denies the enrollee's request.

Example 8C: A consumer is re-enrolled in effectuated coverage with APTC for the upcoming plan year, meaning that no binder payment is required. The issuer does not receive January's premium

[80] In the event an issuer erroneously cancels or terminates a policy, coverage should be reinstated back to the effective date of the erroneous termination or cancellation or restored prospectively if requested by the enrollee. See 45 CFR 155.420(d)(4).

payment by the deadline and places the enrollee in a three-month grace period starting January 1. The issuer does not receive any further premium payments by March 31 and terminates the enrollee's coverage effective January 31. In June, while conducting an audit of its payment system, the issuer realizes that it did receive premium payments from the enrollee for January-March, but these were not reflected on the enrollee's account due to a system error. The issuer contacts the enrollee to offer reinstatement (either retroactive back to February 1 or prospective beginning July 1, at the enrollee's option). The enrollee requests reinstatement, and the issuer restores coverage effective February 1. To recoup the uncollected premium for April-June, the issuer (following CMS under-billing policy in **Section 6.7**, **Under-Billed Premiums**), decides to allow the enrollee to pay the under-billed amount in equal installments, beginning with July's premium bill.

8.2 Reinstatements in the FFE

To reinstate an enrollment record, the issuer must submit the reinstatement using an Inbound 834 (IC834) transaction, through the monthly Enrollment Data Reconciliation process via the Reconciliation Inbound (RCNI) file, or through the dispute process to the Enrollment Resolution and Reconciliation (ER&R) contractor. Although issuers still have the option to utilize the monthly Enrollment Data Reconciliation and ER&R channels to reinstate a policy, CMS policy is for issuers to use the IC834 reinstatement method whenever possible, as it provides a streamlined and more efficient method for issuers to update the FFE's enrollment data with the issuer's enrollment data. In order for a policy to be eligible for an Inbound reinstatement, the policy must have been previously cancelled or terminated by the issuer with an end date prior to the current date (dental policies voluntarily terminated or cancelled by the enrollee may however be reinstated using the IC834 reinstatement method), be from the current or immediately prior plan year (prior-year reinstatements will be accepted until May 1), and still be in a terminated or cancelled state in the FFE. The issuer reactivates the enrollment as if it were never terminated or cancelled, and provides coverage based on the original effective date, maintaining all out-of-pocket accumulators. Regardless of channel (IC834 reinstatement vs. Monthly Recon vs. ER&R), the issuer should submit the reinstatement as soon as possible after they determine that the member was erroneously terminated (see **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**, for more information on submitting through ER&R).

Issuers reinstating a policy via IC834 should not send an IC834 termination/cancellation and an IC834 reinstatement within the same 24-hour time window. This will prevent the possibility of processing both of these transactions in the undesired processing order (i.e., reinstatement processed before termination, when desired outcome was termination processed before reinstatement). Additionally, IC834 reinstatements for health policies will only be accepted for policies that have been terminated or cancelled by issuers for reasons of:

- Non-payment
- Health Insurance Casework System (HICS) Directive
- Fraud
- Free Look
- Anti-Duplication
- Out-of-Area
- Other (Additional Maintenance Reason Code [AMRC] of CANCEL-OTH or TERM-OTH)

Dental policies seeking reinstatement will be accepted for these reasons, but will also be accepted for additional reasons of:

- Voluntary withdrawal.
- Policy that ended as a result of a Change in Circumstance (CIC) (AMRC of CANCELCIC), such as an assister who helped an existing QHP and Qualified Dental Plan (QDP) enrollee with a QHP plan selection and skipped the QDP selection step.

The monthly Enrollment Data Reconciliation process also only allows issuers to reinstate policies that were terminated or cancelled by the issuer. However, the monthly Enrollment Data Reconciliation process has a little more flexibility in allowing reinstatements to be processed when there are multiple segments that have coverage dates that overlap. The monthly Enrollment Data Reconciliation process has logic to clean up overlaps. QDPs can reinstate policies terminated or cancelled by the consumer, call center, or A/B erroneously through the monthly reconciliation process.

The Enrollment Dispute process via ER&R will allow issuers to reinstate policies that were terminated by the enrollee, the FFE, or the issuer. The Enrollment Dispute process is the only process that can allow reinstatements to be processed when the termination or cancellation is not caused by the issuer, with the exception of QDPs. This process is used when issuers cannot reinstate using IC834 or monthly Enrollment Data Reconciliation process. Issuers can submit two types of Enrollment Disputes: HICS Direct Dispute or ER&R Enrollment Dispute Form.

Some common examples of when issuers may use this Enrollment Dispute process are:

- If an enrollee's QHP or QDP is erroneously terminated by the Marketplace Call Center, the Marketplace Call Center will generate a HICS case to reinstate the terminated policy due to Marketplace Call Center error.
- If an enrollee's QHP or QDP coverage is erroneously terminated by themselves or someone acting on their behalf with a future termination date (e.g., consumer's coverage has a termination/end date set for the end of month), but a HICS case was entered before the termination date to reinstate coverage as if never terminated.
- There are also some circumstances where an Appeals determination will ask an issuer to reinstate an Exchange enrollment that was terminated for no longer being eligible (NLE) for Exchange coverage. Issuers must use the HICS Direct Dispute process to request the reinstatement. These processes are explained more in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.
- There are also circumstances where a consumer's policy was cancelled or terminated due to cancelled policy overlaps scripts (see **Section 11.1**, **Introduction**, for more information on overlaps scripts), as indicated in the case narrative, and the consumer requests reinstatement through HICS. Issuers must use the HICS Direct Dispute process to request reinstatement and must include the policy ID to be reinstated.
  The HICS Direct Dispute process will adjust the overlapping policies across different Health Insurance Oversight System (HIOS) IDs.

Finally, the Enrollment Dispute process can process some reinstatements that need to be processed before the updated RCNI is submitted.

- These reinstatements require using the reinstatement tab on the Enrollment Dispute Form.
- These reinstatements require an end date of December 31.

- This process is only for when the IC834 reinstatement process will not work (multiple overlapping segments).
- These reinstatements do not require the RCNI to reflect the correct enrollment date and effectuation status.

The Operational Analytics and ER&R contractors provide the Marketplace Call Center with reports flagging individuals for whom issuers have submitted reinstatement disputes. The Marketplace Call Center representative advises an impacted enrollee that they are still enrolled in the plan and that CMS is working to correct the status in HealthCare.gov. If the impacted member has had a CIC and is seeking to update their information with the FFE, the Marketplace Call Center representative will process as follows, depending on whether the CIC triggers a Special Enrollment Period (SEP):

- If the CIC triggers an SEP, the Marketplace Call Center representative processes the CIC via an 834 enrollment with a prospective date, by updating the application. Routine overlap cleanup runs eliminate the duplicate coverage, providing the original eligibility for the segment of the enrollment starting January or later, and the post-CIC eligibility for the policy segment going forward.
- If the CIC does not trigger an SEP, the Marketplace Call Center representative may initiate a HICS case for the issuer for review. The FFE regularly sends reinstatement requests from individuals to issuers via HICS. CMS expects issuers to review these matters and determine if issuer error occurred warranting a reinstatement.
- If there is a claim of Exchange error or misrepresentation that led to the reinstatement request, the case should be reviewed by a CMS caseworker. If no external notes are present from a CMS caseworker in this scenario (approving or denying the request), issuers must initiate a HICS plan request requesting CMS caseworker review.

9. Enrollment Data Alignment (Applicable to Individual Market FFE, QHPs/QDPs)

9.1 Introduction

Enrollment Data Alignment (EDA) ensures that Qualified Health Plan (QHP) issuers, Qualified Dental Plan (QDP) issuers, and the Exchange have equivalent enrollment information. Accurate enrollment information allows CMS to make correct payments for advance payments of the premium tax credit (APTC), and to assess Federally-facilitated Exchange (FFE) user fees. It also prevents multiple enrollments by one individual and ensures that Exchange enrollees receive an accurate Form 1095-A.

The intent of this section is to provide issuers with an overview of the processes necessary to align enrollment data with CMS on a monthly basis. Participation in EDA is essential for data consistency and to support correct policy-based payments (PBPs), user fee calculations, consumer Form 1095-A generation, batch auto-renewal, and follow-on actions by enrollees on the FFE. FFE EDA between CMS and issuers is ensured by Inbound 834 (IC834) transactions, the Enrollment Data Reconciliation process, and the dispute resolution process.

IC834 should always be used whenever possible to make basic updates to the status of an enrollment. Although certain data may be updated by both IC834 and monthly Enrollment Data Reconciliation, IC834 provides a much faster update to the policy and is the preferred method of EDA. These transactions must pass stringent data quality checks and do not allow issuers the flexibility to change certain data elements, such as the Benefit Start Date. The following data elements may be updated using IC834 with the respective transaction type:

- Effectuation Status (Confirmation Indicator): Effectuation, Cancellation
- Issuer-Assigned Subscriber, Member, and Policy ID: Effectuation, Maintenance (ICM834)
- Benefit End Date and Financial End Dates: Cancellation, Termination
- Do Not BAR (Batch Auto Re-enrollment) Indicator: Termination
- Last Premium Paid Date: Effectuation
- Superseded Indicator: Termination
- Reactivate Coverage: Reinstatement
  NOTE: In order for an IC834 reinstatement to be accepted, the policy the issuer wishes to reinstate must have been previously terminated or cancelled by the issuer and remain in an issuer-initiated cancelled or terminated status in the FFE system. An exception is for dental policies which were voluntarily terminated or cancelled by an enrollee or agent or broker (A/B). The FFE will accept Inbound reinstatements for dental policies ended for these reasons as well as issuer-initiated action.

Monthly Enrollment Data Reconciliation allows issuers and CMS to compare enrollment data before each payment cycle. While IC834s offer haste and disputes a policy-level look at the data, monthly Enrollment Data Reconciliation has greater flexibility to match enrollees between the FFE and issuers and then clean up records using an algorithm. Enrollment Data Reconciliation also has the capability to update more fields on each enrollment record. The FFE creates an enrollment snapshot (Enrollment Pre-Audit File) monthly, providing issuers with a comprehensive view of a single year of FFE enrollment data to use as the basis of reconciliation. This snapshot data is distributed to issuers in a monthly file. Issuers submit a snapshot of their enrollment system in the Reconciliation Inbound

(RCNI) file each month. The FFE compares FFE and issuer data field-by-field and flags updates for issuers and the FFE based on a set of business rules regarding enrollment and data ownership. Certain data elements such as APTC and QHP ID are considered "FFE-owned" and other elements such as effectuation status and issuer-assigned IDs are considered "issuer-owned." The result of this comparison is shared with issuers on the Reconciliation Outbound (RCNO) file, and updates FFE data.

While issuers can update the same data elements through Enrollment Resolution and Reconciliation (ER&R) disputes, the monthly Enrollment Data Reconciliation process should be leveraged in all available instances that cannot be handled through IC834 before attempting to update through ER&R disputes. Files must pass basic formatting checks and meet requirements based on enrollment policy and technical business rules before updates are made to the FFE. Refer to **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.

Issuers should primarily use the monthly Enrollment Data Reconciliation process to update the following fields:

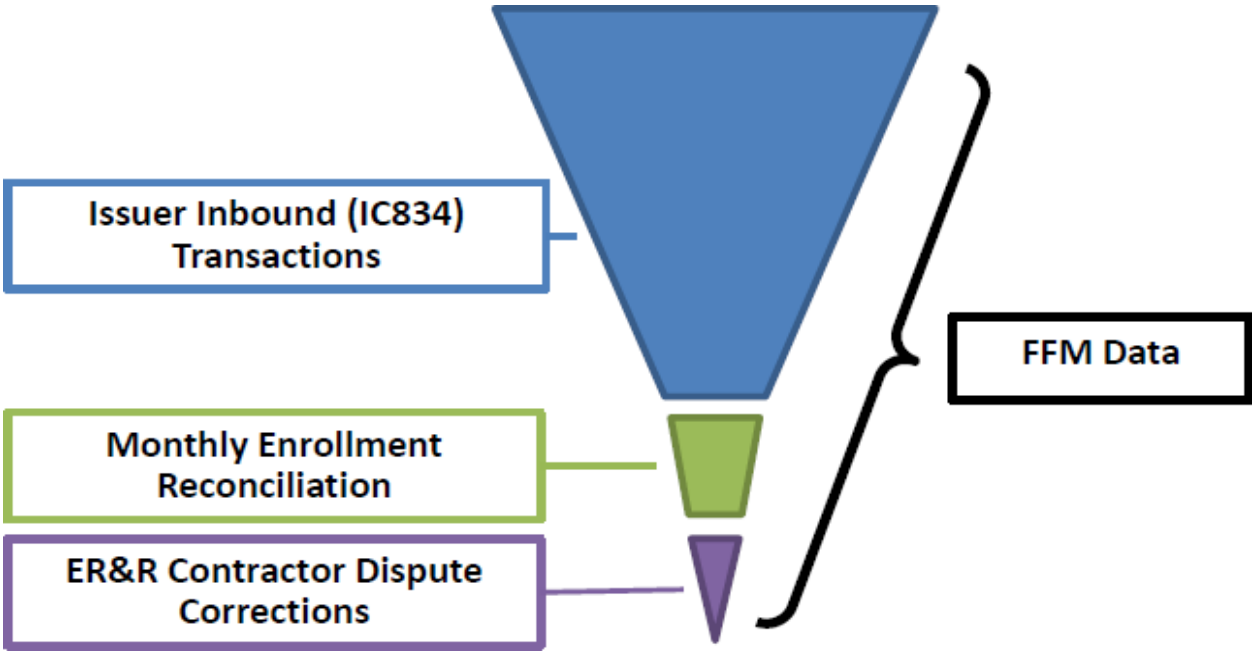
- Benefit Coverage and Financial Dates
- Tobacco Use Status
- Total Premium Amount
- Enrollee Mailing Address

Resolution of Enrollment and Payment Discrepancies (Disputes) corrections may involve manual inspection of a policy by the ER&R contractor, and direct contact with the issuer, and should represent the smallest contingent of enrollment updates. Refer to **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.

Though issuers can provide updates to the FFE through any of these processes, issuers should prioritize the IC834 process to make data updates. IC834 transactions are processed on a daily basis and are the best way to ensure the FFE is updated timely. The monthly Enrollment Data Reconciliation process should only be used to update the FFE in situations where the IC834 process is unable to make the necessary updates. The dispute process should be utilized for prior-year disputes when the Enrollment Data Reconciliation and IC834 processes have ended and for data scenarios that cannot be resolved via the IC834 or Enrollment Data Reconciliation processes.

Exhibit 23 represents the volume of policy updates performed by each component of EDA in the FFE.

Exhibit 23: Volume of Policy Updates Performed



Additional information can be found in the private issuer community on CMSzONE using the following links:

https://zone.cms.gov/document/834-enrollment-0

https://zone.cms.gov/document/enrollment-data-reconciliation

https://zone.cms.gov/document/enrollment-resolution-and-reconciliation

NOTE: Issuers will need to log in to CMSzONE to access these links.

9.2 IC834

ASC X12 834 transactions between the FFE and issuers are conducted in two ways: outbound 834 (FFE to issuer) and IC834 (issuer to FFE). IC834 processing represents issuer responses to enrollment activity in the Exchange and should be used by the issuer community whenever possible as the first and best means of updating and aligning the enrollment data stored in the FFE, with the issuer's current enrollment data. An issuer's submission of an IC834 to the FFE communicates payment/non-payment in the issuer's system, as well as other updates, by using one of five possible Inbound enrollment transactions:

1. Effectuation-typically generated after the issuer has received initial enrollment information from the FFE in the form of an Initial 834 (I834), the issuer has received a binder payment from a new subscriber, and the policy has been made active in the issuer's system/records.
2. Cancellation-typically generated when the enrollment is ended with no actual coverage for enrollee(s) due to non-payment, fraudulent activity, directive from a Health Insurance Casework Systems (HICS) case, or other reasons. CMS expects that the issuer will send the appropriate transaction type, (i.e., non-payment vs. other for terminations or cancellations associated with the cancellation).

3. Termination-typically generated following an effectuation when the enrollment is ended after some period of coverage for enrollee(s) due to non-payment, fraudulent activity, directive from a HICS case, or other reasons. CMS expects that the issuer will send the appropriate transaction type, (i.e., non-payment vs. other for terminations or cancellations associated with the termination).
4. Inbound Maintenance-typically generated following an effectuation to update the Issuer-Assigned IDs on file for the FFE policy (Issuer-Assigned Policy ID, Issuer-Assigned Subscriber ID, and Issuer-Assigned Member ID).
5. Reinstatement-typically generated following an inadvertent or erroneous issuer-driven termination or cancellation to re-activate coverage for the FFE policy.

The intended result of IC834 transaction processing is a policy being updated in the FFE, and in order to ensure timely updates are made, IC834s are processed continuously throughout the day. However, IC834 submissions must pass stringent data quality checks and do not allow issuers the flexibility to change certain data elements, such as the Benefit Start Date. The first validations occur at Electronic Data Interchange (EDI) level. EDI platform performs standard Workgroup for EDI (WEDI) Strategic National Implementation Process Group (SNIP) Levels 1–7 validation on the EDI formatted data elements. If the IC834 passes EDI validation, the issuer will receive positive Interchange (TA1) and Functional Group Level (999) acceptance acknowledgement, and the X12 IC834 will be converted to an XML file and sent to the FFE for further processing. If the IC834 fails EDI validation, issuers will receive a negative TA1, and the file will not be passed to the FFE for further processing.

Once the XML has been generated, the transactions are sent to the FFE. At this point, the second level of validation occurs, and includes checks for matching elements (e.g., benefit start date, policy numbers, and policy status in the FFE). If the IC834 contains errors, issuers will receive a rejected Business Application Acknowledgement (BAA) XML file with error codes, which correspond to a specific error(s) found within the IC834. The BAA will assist issuers in determining what data is incorrect for their IC834 submission, and aid in correctly modifying that data so the rejected IC834 can be resubmitted. If no rejected BAAs are generated, the IC834 will successfully update the FFE database. BAAs are aggregated and sent daily to issuers around 2:00 p.m. ET. Issuers can expect to receive BAAs for submissions made the previous day. Issuers should be aware that positive BAAs are not sent to issuers. If an issuer does not receive negative BAAs for their IC834 submissions and has received positive TA1 and 999 acknowledgements, the submissions can be considered successfully received and processed by the FFE. Issuers can monitor IC834 submission metrics through two standardized weekly reports: the Production Operations (PO) Summary and the PO Detailed (OP834T) reports. The PO Summary report provides aggregate data on accepted and rejected IC834 submissions, including high-level rejection reasons. The PO Detailed report delivers comprehensive, granular information on rejection reasons, including details related to rejected BAAs. Both reports are delivered via Electronic File Transfer (EFT) every Wednesday using their respective function codes, 834PO for the PO Summary and OP834T for the OP834T and reflect data for the preceding Monday through Sunday reporting period.

The FFE delivers monthly Enrollment Alignment Performance Summary (EAPS) Reports that establish the expected acceptance and reliance rates for 834 submissions. Issuers are expected to make their best effort to achieve and maintain the metrics established by CMS. Issuers are also expected to respond to inquiries from the FFE or Account Managers to explain the reason(s) for not meeting the established rates and provide plans to meet the goals within a reasonable time frame.

As previously mentioned, IC834 should be used by issuers to perform updates to enrollment data in the FFE whenever possible. However, there are instances when certain data cannot be updated via IC834, or certain scenarios prohibit the use of IC834. In these cases, issuers should utilize the Enrollment Data Reconciliation or ER&R channels in order to make the necessary enrollment data updates.

For more information on IC834s, refer to the following guidance, located on CMSzONE at https://zone.cms.gov/document/834-enrollment-0:

- IC834 CMSzONE Page
- M834 Operations Manual
- CMS X12 834 Companion Guide
- ASC X12 TR3 005010 | 834 Benefit Enrollment and Maintenance Implementation Guide **NOTE**: Due to copyright laws, this guide must be purchased directly from X12.

For questions or inquiries about IC834, contact Inbound834@cms.hhs.gov.

9.3 Enrollment Data Reconciliation and Pre-Audit Files

FFE Enrollment Data Reconciliation is a monthly process, starting each month with a comprehensive extract of the FFE's enrollment data that is typically pulled at 6:00 p.m. ET on the 15th of the month. This extract provides a snapshot of enrollment data in the FFE for enrollment and payment purposes. It is then formatted and distributed to each QHP and QDP issuer as an Enrollment Pre-Audit File. The Enrollment Pre-Audit File is not in EDI 834 format; it is a pipe-delimited flat file that issuers may choose to process directly or convert into a readable format such as Excel.

Each Enrollment Pre-Audit File refers to a distinct plan year, is aggregated by Trading Partner ID, and then transmitted to issuers via EFT. These files are delivered to the same location an issuer receives daily EDI 834 traffic. Enrollment Pre-Audit Files can be identified by the function code AUDYY (where YY is the final two digits of the plan year referenced by the file) for plan years 2017 and earlier, or AUDY (where Y is the final digit of the plan year referenced by the file) for plan years 2018 or later.

Upon receipt of an Enrollment Pre-Audit File, the issuer should compare the file to the enrollment data in the issuer's system and process any enrollments or updates from the Pre-Audit File that are missing or incorrect in the issuer's system. If the issuer feels there is incorrect policy or member data reflected on the Pre-Audit File, the issuer should use the appropriate EDA channel (IC834, monthly Enrollment Data Reconciliation, or ER&R disputes) to update the FFE. If CMS has determined that a specific enrollment action failed to convey to the issuer via standard EDI 834 transaction, the corresponding enrollment record(s) in the Enrollment Pre-Audit File will be flagged in the Missing Outbound 834 Indicator field. Issuers should closely review these records and apply the necessary updates to their system each month.

Likewise, if an EDI 834 transaction failed but was later successfully retransmitted to the issuer via I834RT File, the corresponding enrollment record(s) on the Enrollment Pre-Audit File will be flagged as such. Issuers should ensure the enrollment updates have been made in their system either via the I834RT file, or the Enrollment Pre-Audit File.

Also, as part of monthly Pre-Audit processing, CMS identifies instances of overlapping or duplicate coverage for the same individual across the FFE. In cases of duplicate or overlapping coverage, CMS will align the enrollment records (with deference to the latest action taken by the enrollee) to eliminate

the overlap or duplicate record. This may result in adjustment of benefit coverage dates or cancellation of an enrollment span on the FFE. Enrollment records that have been adjusted by the overlap process are flagged accordingly on the Enrollment Pre-Audit File with an indicator that informs the issuer as to whether the overlap was within the same Health Insurance Oversight System (HIOS) ID, or with a different HIOS ID. **Issuers must act upon the cancellations and terminations flagged on the Pre-Audit File as this information will not be sent via EDI 834.** Records impacted by the overlap cleanup are only flagged in the month in which the overlap was corrected; as such, issuers must address the records flagged by the cleanup on every Pre-Audit File received from the FFE.

CMS also conducts a monthly date of birth (DOB) cleanup process. When a DOB change is entered in the FFE, the DOB and premium are adjusted as needed going forward, but no update is made to the historical records for that plan year. The DOB cleanup process rolls back the changes to prior policies and policy segments on the same application. If the DOB change on the historical update would cause a change in premium, the premium adjustment and DOB will be applied to historical records. If the premium on the historical record had been previously updated through the Enrollment Data Reconciliation process, a DOB change will be made but no update to the premium will be applied. Issuers should note that APTC will only be adjusted by this cleanup if the new Total EHB (essential health benefits) Premium would be lower than the Applied APTC Amount; in that case the Applied APTC Amount would be lowered to match the new Total EHB Premium.

As with the overlap cleanup process, issuers will only receive notification of adjustments made by the DOB cleanup on the monthly Pre-Audit File. **Issuers must act upon the DOB and any financial changes flagged on the Pre-Audit File as this information will not be sent via EDI 834.** Records impacted by the DOB cleanup are only flagged in the month where the historical records were corrected; as such, issuers must address the records flagged by the cleanup on every Pre-Audit File received from the FFE.

> For additional guidance and technical specifications for the Enrollment Pre-Audit File, refer to the Enrollment Data Reconciliation section in the private issuer community on CMSzONE, located at https://zone.cms.gov/document/enrollment-data-reconciliation. Specifications for Standard Issuer Enrollment Data Files are also available at this location.

In order to identify discrepancies and reconcile enrollment data with the FFE, each month issuers are required to similarly extract their enrollment data by plan year and submit an RCNI file to the FFE. Issuers must submit the RCNI file by the deadline outlined on the *Pre-Audit and Reconciliation Calendar* located at https://zone.cms.gov/document/enrollment-data-reconciliation. Submittal or non-submittal of your RCNI will be reflected in your Reconciliation Submission EAPS Report metric score.

As with the Enrollment Pre-Audit File, the RCNI file is a pipe-delimited flat file that will be submitted to the FFE via EFT. The RCNI file is a snapshot of the issuer's enrollment data for a specific plan year and must include information about current enrollees, cancelled enrollment records, and terminated enrollments. The RCNI files include both enrollment and financial data elements. The enrollment data submitted by the issuer on the RCNI file should be aligned to transactions received from the FFE through the date of that month's FFE Pre-Audit Extract (typically the 15 of the month) to reduce timing issues when compared to the FFE data. For additional guidance and technical documentation on the RCNI, refer to the Enrollment Data Reconciliation page in the private issuer community on

CMSzONE, located at https://zone.cms.gov/document/enrollment-data-reconciliation. The Reconciliation Quality metric in the EAPS Report will reflect the issuer's RCNI success rate.

CMS compares the data extracted from the FFM Extract to each issuer's RCNI files through an automated process. The automated process matches records based on a unique collection of field information and identifies discrepancies between issuer and FFE data. This process uses current enrollment policy rules to determine if the discrepancy needs to be resolved in the FFE or by the issuer (or in some cases both the FFE and the issuer must update a value). The results of the record-matching and data comparison are distributed to issuers in the RCNO file. The RCNO file provides record-level flags on each record to show the results of matching and highlight records on which the FFE or issuer are expected to take action; field-level flags are also provided on matched records in the file to show the results of field-level data comparison and, if necessary, which system is expected to update to the other's value. The "E" and "P" Flags metric in the EAPS Report may reflect the results of the record-level matching. If the FFE is unable to find a match for an FFE policy in the issuer data, the UFEs metric in the EAPS Report may reflect these results.

As with the Enrollment Pre-Audit File, each RCNO file is aggregated by Trading Partner ID and transmitted to issuers via EFT. These files are delivered to the same location an issuer receives daily EDI 834 traffic. RCNO files can be identified by the function code RCNOYY (where YY is the final two digits of the plan year referenced by the file) for plan years 2017 and earlier, or RCNOY (where Y is the final digit of the plan year referenced by the file) for plan years 2018 or later.

For additional information on the business rules used in automated Enrollment Data Reconciliation and the record and field-level flags on the RCNO file, refer to the *Enrollment Reconciliation Education Suite* located in the private issuer community on CMSzONE at https://zone.cms.gov/document/enrollment-data-reconciliation.

It is expected that issuers will correct the enrollment data in their systems based on the updates specified for the issuer in the RCNO file. If the issuer disagrees with a discrepancy resolution flag set by the automated process or needs to resolve a discrepancy in a way that cannot be done through automated Enrollment Data Reconciliation, they may submit a dispute to the ER&R contractor for resolution.

9.4 Resolution of Enrollment and Payment Discrepancies (Disputes)

As described in **Section 9.3**, **Enrollment Data Reconciliation and Pre-Audit Files**, CMS regulations and guidance require issuers that participate in the FFE to reconcile their records monthly. The monthly Enrollment Data Reconciliation process is an automated process to compare the FFE data to the issuer enrollment records to determine any discrepancies. This process uses current CMS enrollment policies and technical business rules to determine when the FFE's records may be updated and when the issuer should update their system to match the FFE. If an issuer disagrees with a decision made in the automated monthly Enrollment Data Reconciliation process, they can file a dispute with the ER&R contractor. The ER&R contractor is responsible for resolving issuer-initiated enrollment and payment discrepancies that cannot be resolved through the automated Enrollment Data Reconciliation process or the IC834 process.

ER&R applies automated and manual rules to ensure disputes are resolved in accordance with approved enrollment and payment guidelines. Following the resolution of any discrepancies, the

ER&R contractor submits changes to the FFE or notifies issuers to update their respective data. Issuers see updates to the FFE reflected on the Pre-Audit File within 1–2 payment cycles.

Although disputes will be processed for three years after the initial plan year, issuers are strongly encouraged to submit disputes as soon as possible upon identification of a discrepancy to help ensure the FFE issues an accurate Form 1095-A to individuals in advance of the tax filing deadline as well as ensure proper and timely payments. To help ensure payment and Enrollment Disputes are processed in the same cycle (when possible), issuers should submit disputes by the deadline identified on the *Pre-Audit and Reconciliation Calendar* located at https://zone.cms.gov/document/enrollment-data-reconciliation.

9.4.1 Disputes Timeline

It is important that issuers resolve policy data alignment inaccuracies during the plan year as quickly and accurately as possible. Issuers should ensure that dispute submissions can be successfully processed and contain accurate enrollment and/or payment data. Rejected disputes may cause delays in updating data and can create an adverse consumer experience. By eliminating data inaccuracies, issuers can avoid inaccurate APTC and user fees, incorrect BAR enrollments, and inaccurate Forms 1095-A. CMS has established timelines issuers must follow for submitting disputes. [81]

9.4.2 90-Day Requirements

Per 45 CFR 156.1210(a), issuers have 90 calendar days from receiving the payment and collections report to review discrepancies and submit disputes. Issuers should pay attention to their 90-Day Inaccuracies metric on the EAPS Reports, as this metric will indicate that the issuer has disputes over 90 days that they need to submit. Starting in 2023, CMS included a dispute timeliness metric in the EAPS Reports, Average Dispute Age, which will serve as notification to issuers if they are not submitting disputes in a timely manner.

9.4.3 Disputes Over 90 Calendar Days 15-Day Requirement

It should be rare, but in a circumstance where the issuer identifies a discrepancy that is outside of the initial 90-day period, the issuer must notify CMS within 15 calendar days of identification of a dispute per 45 CFR 156.1210(b).

9.4.4 Post-Deadline Inaccuracies

Starting January 1, 2024, per 45 CFR 156.1210(c), issuers may only dispute inaccuracies identified after the initial 90-day period up to three years after the end of the plan year. Discrepancies identified after this time frame are considered Post-Deadline Inaccuracies (PDIs). If an issuer discovers a PDI that, at the HIOS level, results in a payment owed to the Department of Health & Human Services (HHS), the issuer must notify the FFE, State-based Exchange on the Federal Platform (SBE-FP), or State-based Exchange (SBE) (as applicable) and repay any such overpayment. Payment adjustments to correct PDI-related overpayments will not result in an update to the Exchange enrollment data and subsequently will not generate consumer Forms 1095-A. In addition, HHS will not pay an issuer after the three-year reporting deadline for any underpayments discovered.

[81] See 45 CFR 156.1210.

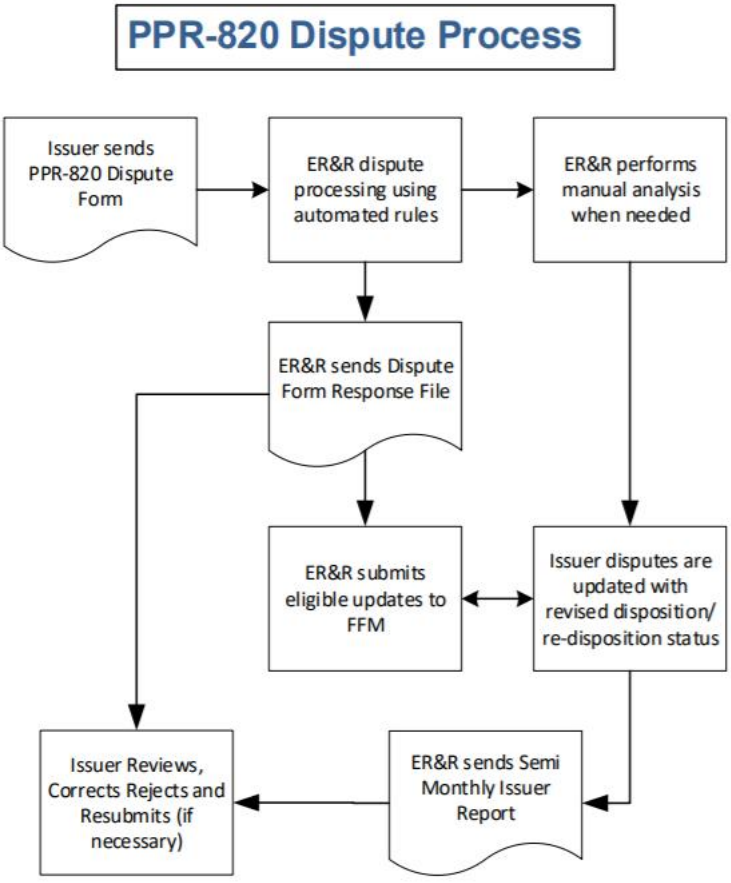
To start the PDI repayment to HHS, an issuer must fill out the PDI approval form located on the System of Exchange Enrollment Data (SEED). Issuers can locate additional information on PDIs at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation. For more information on submitting the approval forms, issuers should review the SEED Companion Guide, which is available on CMSzONE at https://zone.cms.gov/document/system-exchange-enrollment-data-seed.

9.4.5 Audits and Disputes

A policy that was part of a Phase 2 PBP issuer audit is typically not able to be re-disputed and may only be adjusted due to a consumer-initiated appeal, barring circumstances where the issuer identifies a discrepancy that results in payment owed to HHS that was not resolved in audit. Issuers should use the PDI dispute process described in **Section 9.4.4**, **Post-Deadline Inaccuracies**, to notify CMS.

9.4.6 Payment Dispute Process

Exhibit 24: PPR-820 Payment Dispute Process



Issuers can submit disputes through three different avenues: 1) Payment Disputes, 2) Enrollment Disputes, or 3) HICS Direct Disputes. The Payment Dispute (PPR/820 disputes) process allows the issuer to submit unexpected or missing payments identified in the PPR or HIX 820.

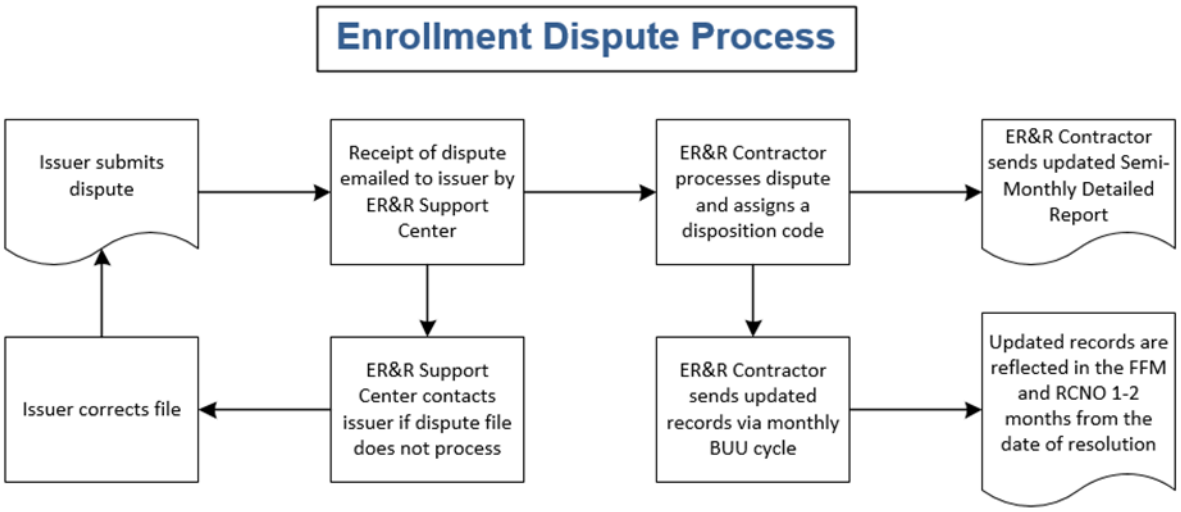
To submit a Payment Dispute, the issuer should submit the Financial Transfers (FT) PPR-820 Dispute Form (Payment Dispute Form) to the ER&R contractor in an Excel or Pipe Separated Value (PSV)

format. Issuers must submit the PPR/820 Dispute Forms via EFT, which uses the same EFT setup as the 834/820 file transfer process, or through the SEED Dispute Upload tab. Issuers must complete the dispute form using data from either the PPR or the HIX 820. For additional information on how to submit Payment Disputes to the ER&R contractor, including the naming conventions, file specifications and additional guidance, refer to the *Enrollment and Payment Disputes TRG* located on CMSzONE at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation.

When an issuer submits the Payment Dispute Form, they will receive a PPR/820 Dispute Response File within 1–2 business days. The response file provides the results for each dispute submitted. If a dispute is flagged with an In Process/In Analysis disposition code, the issuer will need to monitor the Semi-Monthly Detailed Reports for updates. These reports provide dispositions for Enrollment, Payment and HICS Direct Disputes and are provided bi-monthly on the 1st or the 16th (or the first business day thereafter). For additional guidance on the Response File and the Semi-Monthly Detailed Reports, including the disposition codes and descriptions, refer to the *FFE Payment Dispute Disposition and Detail Code List* located at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation.

9.4.7 Enrollment Dispute Process

Exhibit 25: Enrollment Dispute Process



The Enrollment Dispute process allows issuers to submit disputes based on enrollment data found on the Pre-Audit or RCNO. As of May 1, 2019, issuers must first receive approval from their Account Manager before any prior-year disputes can be submitted to ER&R. Each subsequent plan year will require Account Manager approval as of May 1 of the following year. Disputes caused by a HICS case do not require Account Manager approval. The issuer will need to submit the HICS case, if applicable, directly to the ER&R contractor or provide the HICS case number on the dispute form.

To submit an Enrollment Dispute, issuers should submit the Enrollment Dispute Form in an Excel or PSV format similar to the Payment Dispute Form. Issuers must also submit the Enrollment Dispute Form through EFT or the SEED Dispute Upload tab.

There are 11 tabs on the Enrollment Dispute Form. The first three tabs contain guidance and instructions, and the other eight tabs are for issuers to fill out to submit corrections. These tabs are:

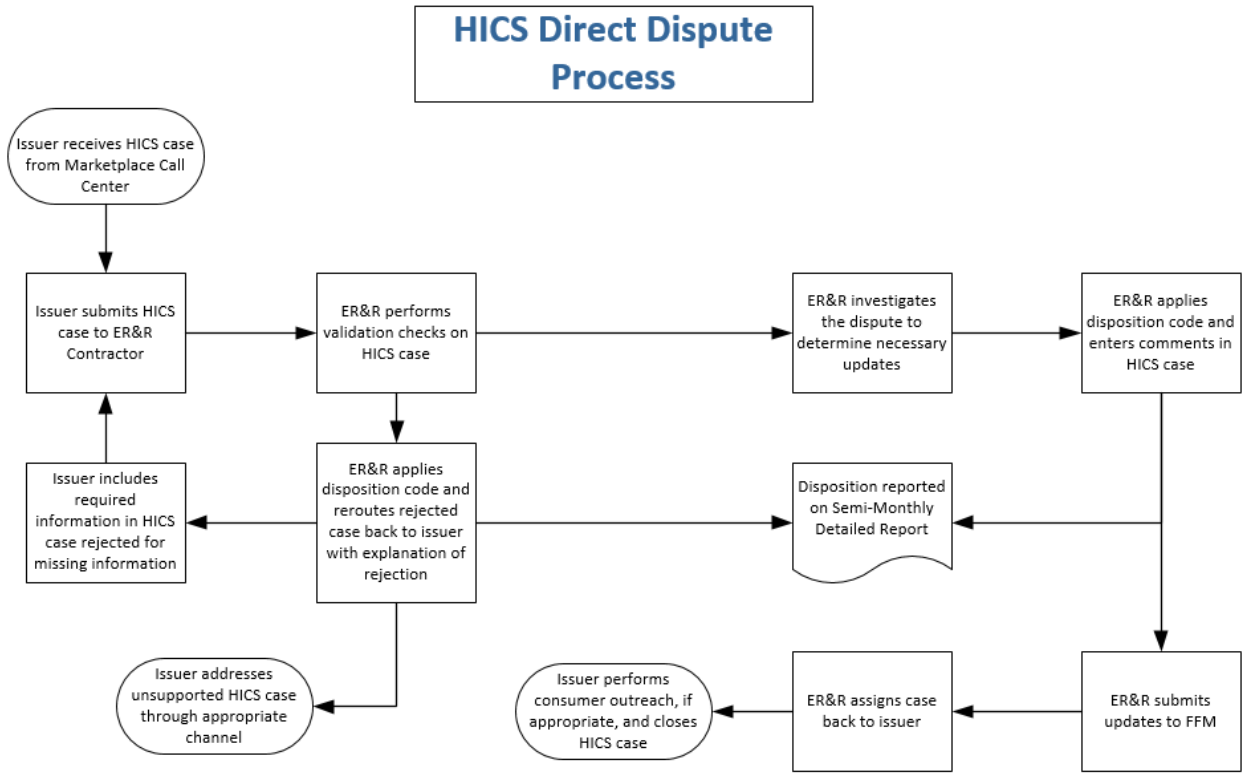
1. Discrepancy Dispute Tab – Allows issuers to dispute discrepancies identified on the RCNO.
2. Rejected Enrollments Tab – Allows issuers to reject FFE enrollments, including BAR enrollments.
3. Reinstatement End Date 12.31 Tab – Allows issuers to reinstate policies to a December 31 end date.
4. Newborn Premium Updates – Allows the issuer to report a newborn member who qualifies for a free premium coverage period in accordance with applicable state laws.
5. Enrollment Blocker Tab – Allows issuers to update financial information or other enrollment information when an error occurs in the FFE.
6. Mailing Address Change – Allows issuers to update mailing addresses.
7. Agent Broker Information – Allows issuers to add, change, or remove A/B information if presented with an Agent of Record or Broker of Record documenting consumer consent. **NOTE**: Although issuers have the ability to change A/B data through an ER&R Enrollment Dispute, issuers may not make changes to a consumer's application data, including the A/B National Producer Number (NPN), without the express consent of the applicant or enrollee. A/B information should always stay on the policy or application unless the consumer directs the issuer to remove or change the information based on receipt of an updated Agent of Record or Broker of Record. Compensation decisions by the issuer based on A/B status are independent of the FFE application and/or enrollment records and should not generally initiate a change to the consumer record. Issuers should never submit dummy NPNs. As of Fall 2024, issuers are only able to update existing A/B information with prior Account Manager approval. If the issuer's state Department of Insurance has a sanctioned Book of Business transfer process, the issuer can submit a Book of Business Transfer update request form to their Account Manager to attest that they have followed state requirements. Upon approval by the Account Manager, the issuer can submit the A/B updates to ER&R.
8. Unauthorized Plan Switch (UPS) – Allows issuers to reinstate policies that were terminated/cancelled due to A/B activity without consumer consent.

It is important to note that the data submitted on the RCNI must match the data the issuer submits on the Enrollment Dispute Form. However, policies submitted on the Rejected Enrollment, Reinstatement End Date 12.31, and Enrollment Blocker Tab do not require the data to match on the RCNI prior to submission. For additional information on how to submit Enrollment Disputes to the ER&R contractor, including the naming conventions, file specifications and additional guidance, refer to the *Enrollment and Payment Disputes TRG* located on CMSzONE at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation.

Enrollment Disputes do not get a response file within 1–2 business days. The status of an Enrollment Dispute is reported on the Semi-Monthly Detailed Reports. As mentioned previously, these reports provide dispositions for each disputed record for Enrollment, Payment and HICS Direct Disputes and are provided bi-monthly on 1st or the 16th (or the first business day thereafter). For additional guidance on the Semi-Monthly Detailed Reports, including the disposition codes and descriptions, refer to the *FFE Payment Dispute Disposition and Detail Code List* located at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation.

9.4.8 HICS Direct Dispute Process

Exhibit 26: HICS Direct Dispute Process



The HICS Direct Dispute process allows issuers to submit a HICS case they receive directly to the ER&R contractor. This process allows issuers to reassign HICS cases to the ER&R contractor. The HICS case will remain open while it is pending with the ER&R contractor, and the time while the case is pending with ER&R does not count toward the HICS resolution time frames (72 hours for Level 1 and 15 days for Level 2). Time begins to run again once ER&R returns the HICS case to the issuer. This allows the issuer time to complete the necessary actions on the HICS case before closing it.

Most updates can be made through the monthly Enrollment Data Reconciliation process. There are limited situations that require HICS cases to be directly disputed to the ER&R contractor for manual review and processing. HICS Direct Disputes are, as of publication of this manual, limited to the following updates:

- Enrollment Blocker (Financial Changes, Removal of a Member, or Tobacco Status)
- Changing Subscriber Dispute
- DOB Dispute
- Applied APTC Amount
- Total Premium Amount
  NOTE: Total Premium Amounts that do not require a HICS case are not eligible for Direct Dispute processing. For additional information on which updates require HICS cases, access the *Enrollment and Payment Disputes TRG* located at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation.
- Term NLE Appeals

- QHP ID/Variant ID
- Cancelled Policy Overlap
- Removal of a Member
  NOTE: ER&R can work with the issuer to provide updated financial information when removing a member from a policy.

For additional information on how to submit HICS Direct Disputes to the ER&R contractor, including steps on transferring HICS files and additional guidance on what can be submitted through this process, refer to the *Enrollment and Payment Disputes TRG* located on CMSzONE at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation.

HICS Direct Dispute responses are included in the comments of the HICS case when it is returned to the issuer. ER&R also applies a disposition code to each HICS Direct Dispute case in the comments section of the HICS case as well as on the Semi-Monthly Detailed Report. As mentioned previously, these reports provide dispositions for each disputed record for Enrollment, Payment, and HICS Direct Disputes and are provided bi-monthly on the 1st or the 16th (or the first business day thereafter). For additional guidance on the Semi-Monthly Detailed Reports, including the disposition codes and descriptions, refer to the *CCIIO Enrollment Disposition Code List* located at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation.

9.5 Unmatched "I" Record

An unmatched "I" record (UIR) is an issuer record assigned an overall record flag of "I" because the monthly Enrollment Data Reconciliation process is unable to directly match to the FFE record. The ER&R contractor analyzes all UIRs on the RCNO to identify possible matches and assigns each record a category to assist issuers with aligning these UIRs.

There are two types of UIRs:

- Unaffiliated Issuer Enrollment (UIE): A UIR in which the ER&R contractor was unable to identify a current FFE record for the consumer
  NOTE: Certain UIEs may be eligible for CMS manual payment.
- Misaligned Issuer Enrollment (MIE): A UIR that the ER&R contractor matched to a current FFE record through additional analysis

The ER&R contractor will send a detailed UIR Report monthly (on the third Friday after RCNO delivery) to impacted issuers only to assist these issuers with resolving UIRs before submission of the next monthly RCNI file. The UIR Report categorizes the UIE and MIE records to assist the issuers with aligning these records. CMS has provided guidance on how to resolve each UIR category. Issuers are expected to review each UIR Report and take action, when warranted, to reconcile the discrepant records.

Annually, CMS will make manual payments of APTC for any remaining eligible UIEs for coverage through May 31 but not for coverage after that date. By April 1, issuers are expected to notify their consumers enrolled in UIE policies that their enrollment through the Exchange will end on May 31 and terminate FFE enrollment for any remaining UIEs. Issuers should conduct outreach to inform their consumers enrolled in UIE policies that the consumers may be entitled to a Special Enrollment Period (SEP) for 60 days and, if applicable, offer the option to continue their coverage outside the FFE after the May 31 termination date.

For more information on resolving UIRs, issuers should refer to the ER&R page on CMSzONE, located at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation.

9.6 SEED

SEED is a web application that provides issuers and third-party administrators (TPAs) with a secure way to access real-time FFE data in a single location while adhering to CMS's privacy and security standards. This resource is used to assist with casework and EDA, and the real-time nature of the data presented allows users to quickly and accurately resolve enrollment and payment issues. Issuers should update their internal procedures to reflect the use of the SEED application for casework and data alignment resolution.

There are four search categories available in SEED: Application ID, Exchange Policy ID, Exchange Member ID, and Exchange Subscriber ID. Users can filter searches by HIOS ID, which is limited to the HIOS IDs the user is authorized to view. Searches for Exchange Member ID and Exchange Subscriber ID can also be filtered by year. Users can sort the search results and can display additional enrollment details by clicking the Details button. Detailed descriptions of all the fields displayed in SEED are located in the Data Dictionary section of the SEED Companion Guide.

SEED users can also upload completed Payment and Enrollment Dispute Forms within SEED, using the Dispute Upload tab. SEED users can either browse to the desired file or drag and drop it into the Dispute Upload screen. After uploading the file, SEED users receive an email notification of the submission, and the ER&R contractor will complete processing the file in exactly the same manner as dispute files submitted through EFT.

SEED users can submit Account Manager Prior Year, PDI, and Account Manager Agent Broker forms to gain Account Manager approval to submit prior-year disputes, disputes subject to the post-deadline inaccuracy guidelines, and Agent/Broker Name/NPN Update disputes for the current year, respectively.

9.6.1 SEED Resources

Issuers are strongly encouraged to access SEED resources available on CMSzONE at https://zone.cms.gov/document/system-exchange-enrollment-data-seed. The resources are as follows:

- SEED Companion Guide: This provides comprehensive instructions for gaining access to and using SEED. This document also contains a data dictionary that includes definitions and descriptions of each data element available in SEED.
- SEED Issuer Approver Guide: This contains comprehensive instructions for SEED Issuer Approvers.
- SEED 101: This offers an overview of the general use and functionality of SEED.
- SEED EDA Help Guide: This provides guidance on ways for issuers to use SEED while working through their casework.
- Overlapping Coverage Quick Guide: This offers guidance on search strategies to avoid same-HIOS overlapping date span deflections on Enrollment Disputes.

10. Forms 1095-A Generation and Corrections

10.1 Form 1095-A Initial Generation Process

Throughout January each year, the Federally-facilitated Exchange (FFE) generates and sends initial Forms 1095-A to tax filers who enrolled in a Qualified Health Plan (QHP) through the FFE during the prior year. Form 1095-A provides enrollees with information about their health coverage so that application tax filers can:

- File their taxes.
- Reconcile advance payments of the premium tax credit (APTC).
- Claim the premium tax credit (PTC).

The information provided on a Form 1095-A is used to complete Form 8962 with the Internal Revenue Service (IRS). Application tax filers must complete and file a Form 8962, regardless of whether they are required to file a tax return, to claim PTC, or be eligible for APTC in future years.

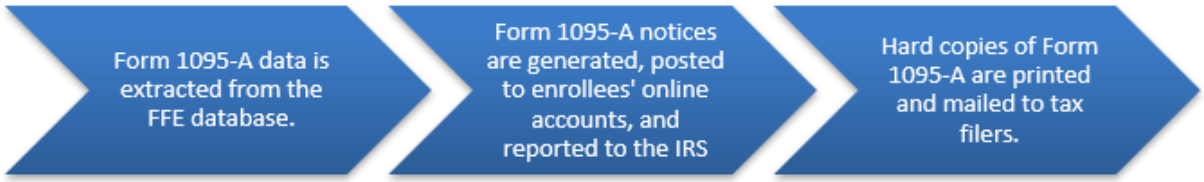
As part of this program, the FFE sends IRS monthly and yearly data regarding all individual enrollment and APTC payments made to QHP issuers on behalf of enrollees, which the IRS uses to validate individuals' Federal income tax returns (e.g., to reconcile APTC, process PTC claims, and grant exemptions). Monthly and annual reports are submitted to the IRS following completion of the plan year, identifying tax filers or other relevant adults who received APTC (or whose tax dependent(s) received APTC) related to an individual market policy purchased through the Exchange. The IRS uses the information in the monthly and annual reports to verify information included on individual-submitted Form 8962.

The FFE processes bi-monthly Form 1095-A Correction Cycles from February through December to provide individuals with corrected Forms 1095-A when FFE data has been updated. The Form 1095-A Corrections Cycles capture FFE data updates initiated by consumers engaging with our Form 1095-A casework process and issuer data updates made through all Enrollment Data Alignment (EDA) channels: Inbound 834s (IC834s), the Enrollment Data Reconciliation process, and Enrollment Resolution and Reconciliation (ER&R) disputes. Issuer-initiated data updates generate Corrected Forms 1095-A and individuals may be required to file an amended Federal income tax return. Approximately 70 percent of corrections are driven by issuer-initiated data changes.

Form 1095-A data is populated from the FFE enrollment data submitted to the IRS, and initial generation occurs in early January, which leads to:

- Forms 1095-A being generated electronically and posted to enrollees' online Marketplace accounts and IRS Individual Online Accounts.
- Hard copies being printed and mailed to all consumers enrolled in FFE QHPs.
- Forms 1095-A data is reported to the IRS.

Exhibit 27: Form 1095-A Generation Process Overview



Issuer participation in all EDA processes (discussed in **Section 9**, **Enrollment Data Alignment (Applicable to Individual Market FFE, QHPs/QDPs)**) is an essential part of ensuring accuracy of Form 1095-A data. CMS performs EDA with issuers to ensure FFE records match QHP issuers' records. If the data is not correct, there are important tax implications, such as enrollees receiving Forms 1095-A with incorrect coverage data that can impact their APTC/PTC reconciliation. Please note that the FFE does not send Forms 1095-A to enrollees only enrolled in dental or catastrophic coverage.

Timeliness of issuer reconciliation is critical. The initial Form 1095-A generation process begins in early January each year and leverages the data captured in the FFE up through the current month when Forms 1095-A are generated. As such, all issuer data should be reconciled each year by the end of November of the current plan year to ensure the data is accurate on an individual's initial Form 1095-A.

If Form 1095-A data is updated in the FFE database after initial Forms 1095-A generation, Corrected and/or Voided Forms 1095-A are automatically generated and mailed to enrollees in the next bi-monthly Form 1095-A Correction Cycle. This leads to enrollee confusion since enrollees are likely not expecting to receive a new Form 1095-A. CMS provides the following guidance to avoid enrollee confusion:

CMS strongly recommends that issuers carefully review their enrollment data and ensure any necessary FFE updates are successfully submitted to the FFE by November to avoid their enrollees receiving Forms 1095-A with incorrect coverage data that can impact their APTC/PTC reconciliation.

Issuers are strongly encouraged to submit disputes as soon as possible upon identification of a discrepancy to allow the FFE to issue accurate Forms 1095-A to enrollees in advance of the tax filing deadline.

10.2 Examples

Example 10A: CMS or an issuer identifies an enrollment data error that affects a high volume of policies for a particular Health Insurance Oversight System (HIOS) ID after the plan year ends but while prior-year Enrollment Data Reconciliation cycles are still active.

Recommended issuer action: While the prior-year Enrollment Data Reconciliation cycle is still active (through March of the plan year following the end of the enrollee's coverage period), updates can be made via automated Enrollment Data Reconciliation or, if appropriate, dispute resolution. Once the Enrollment Data Reconciliation cycle is complete, Corrected or Voided Forms 1095-A will be automatically generated during the next Form 1095-A Correction Cycle and sent to affected enrollees. In this scenario, it will take approximately 1–2 months for enrollees to receive their corrected Form 1095-A.

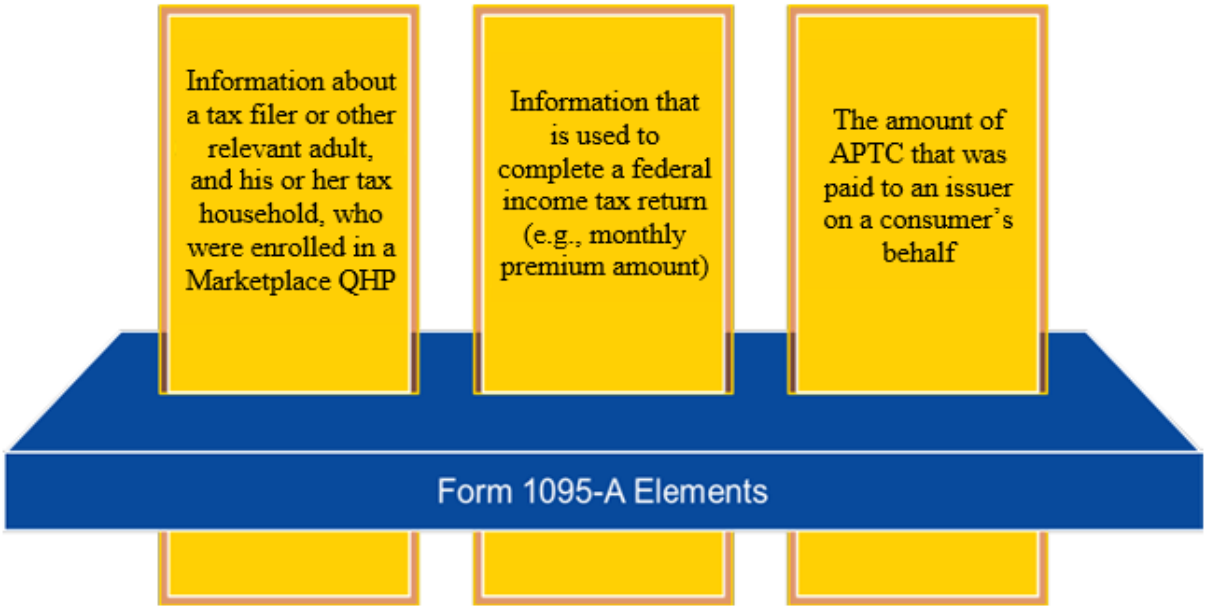
NOTE: If this scenario occurs, issuers are strongly encouraged to contact each affected enrollee so that they know to expect a Corrected or Voided Form 1095-A. CMS has developed the *Form 1095-A Toolkit for Issuer Outreach to Individuals* to assist issuers in conducting Form 1095-A related enrollee outreach. This toolkit is available on CMSzONE at https://zone.cms.gov/system/files/documents/toolkit_for_issuers_form_1095-a_final_clean.pdf.

Example 10B: CMS or an issuer identifies a single policy that requires coverage date changes.

Recommended issuer action: The issuer can submit this type of enrollment through the ER&R dispute process (see **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**). Up to five weeks after dispute resolution, issuers receive a past-year Pre-Audit File reflecting the changes accepted by the FFE.

10.3 Anatomy of a Form 1095-A

Exhibit 28: Form 1095-A Elements



10.3.1 Form 1095-A Part 1: Recipient Information

Part I, lines 1–15, reports information about:

- The tax filer or other relevant adult.
- The insurance company that issued the policy.
- The Exchange where they enrolled in coverage.

Exhibit 29: Recipient Information Section

Part I Recipient Information

1 Marketplace identifier	2 Marketplace-assigned policy number	3 Policy issuer's name	
4 Recipient's name		5 Recipient's SSN	6 Recipient's date of birth
7 Recipient's spouse's name		8 Recipient's spouse's SSN	9 Recipient's spouse's date of birth
10 Policy start date	11 Policy termination date	12 Street address (including apartment no.)	
13 City or town	14 State or province	15 Country and ZIP or foreign postal code	

10.3.2 Form 1095-A Part II: Covered Individuals

Part II, lines 16–20, reports information about each individual who is covered under the tax filer's or other relevant adult's policy, including:

- Covered individual name, Social Security number (SSN), and date of birth (DOB).
- Coverage start and end date.

Exhibit 30: Covered Individuals Section

Part II Covered Individuals

	A. Covered individual name	B. Covered individual SSN	C. Covered individual date of birth	D. Coverage start date	E. Coverage termination date
16					
17					
18					

10.3.3 Form 1095-A Part III: Coverage Information

Part III, lines 21–33, reports information about the tax filer's insurance coverage that they will need to complete Form 8962 to claim the PTC and reconcile APTC, including monthly:

- Enrollment premiums.
- Second lowest cost Silver plan (SLCSP) premium.
- APTC.

Exhibit 31: Coverage Information Section

Part III Coverage Information

Month	A. Monthly enrollment premiums	B. Monthly second lowest cost silver plan (SLCSP) premium	C. Monthly advance payment of premium tax credit
21 January			
22 February			
23 March			

Individuals may not recognize the monthly premium amount (included in Part III, Column A) listed on Form 1095-A because:

- The monthly premium amount is reduced for premiums allocated to benefits exceeding essential health benefits (EHB).
- If individuals were also enrolled in a Qualified Dental Plan (QDP), the monthly premium amount also includes the pediatric EHB portion of QDP monthly premium amounts.
- Issuers prorate the monthly premium for enrollees in cases such as mid-month additions (e.g., birth/adoption) or mid-month terminations (e.g., death, voluntary termination).
- The monthly APTC amount (included in Part III Column C) is the monthly amount of payments that were made to the insurance company to pay for all or part of the premiums for the tax filer's coverage. The FFE will enter "0" in this column if no APTC payments were made.

10.4 How Issuers Should Answer Enrollee Questions About Forms 1095-A

Issuers may hear from enrollees who have concerns about their Form 1095-A; since the Form 1095-A is a record of the prior year's enrollment with the issuer, CMS expects that issuers should be able to answer most questions their enrollees may have. This includes verifying enrollment dates, APTC amounts applied, non-EHB portions of premiums, etc. Enrollees may call with basic questions about the Form, tax filing, or concerns about the data on the Form 1095-A. Responses to basic enrollee questions will depend on the type of issue, and may include:

- Addressing the enrollee's question directly.
- Directing enrollee to call the IRS.
- Directing the enrollee to call the appropriate FFE or State-based Exchanges (SBEs).

10.4.1 Basic Form 1095-A Questions Issuers May Answer

- What is this form I received?
- What is Form 1095-A?
- Where can I find more information or instructions?
- Why didn't I receive my Form for catastrophic plans, non-Exchange plans, and dental plans?
- Where can I find my Form 1095-A online?

10.4.2 Enrollee Questions to Be Directed to the IRS or the Tax Filer's Tax Preparer

- Do I qualify for the PTC?
- What are the requirements for the individual shared responsibility provision through 2018?
- How do I report healthcare coverage on my income tax return?
- Will IRS verify that enrollees had minimum essential coverage (MEC)?
- Where can I find my Form 1095-A in my IRS Individual Online Account?
- I received a Form 1095-A. How should I report this on my income tax return?
- Can you help me complete my income tax return?
- How do I use the Form 1095-A to fill out my Form 8962?
- Can I get a copy of the Form 8965 or 8962?

- What happens if I don't file my income tax return?
- I can't file/can't pay my tax liabilities by the tax deadline (generally April 15). What should I do?
- Why did I receive a 12C letter from the IRS?

10.4.3 Enrollee Questions to Be Directed to the Exchange

- Why did I receive a Form 1095-A?
- I never received a Form 1095-A. How can I get the Form or the information I need?
- Where can I find my Form 1095-A on my Marketplace account?
- What do I need to do with this Form 1095-A?
- What does this information on the Form 1095-A mean?
- I think my Form 1095-A may have gone to the wrong address. What should I do?
- Why did I get more than one Form 1095-A?
- The information on my Form 1095-A does not look correct. How can I change it?

In addition to the background provided in this section, issuers can direct enrollees to find answers to tax questions about Form 1095-A on HealthCare.gov/taxes and/or IRS.gov. If they do not find answers, enrollees should contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

10.5 Form 1095-A Basics for Assisting QHP Enrollees

The following background information can be used when addressing and triaging basic enrollee Form 1095-A questions.

Tax filers receive Forms 1095-A if they or a member of their household were enrolled in a QHP through the Exchange for any months in the plan year, with or without receiving APTC. Forms 1095-A will not be generated for enrollees:

- Enrolled in only a dental or catastrophic plan (since APTC may not be applied to these types of policies, taxpayers are not eligible to receive APTC, nor can they claim the PTC on their tax return).
- Enrolled in a plan outside of the Exchange.

Each Form 1095-A is specific to a plan year and is not necessarily comprehensive. Just as some tax households receive multiple W-2s if individuals have multiple jobs, some tax filers will get multiple Forms 1095-A if they were covered under different plans or made changes to their tax household during the year. There are several reasons why a tax filer may receive more than one Form 1095-A:

- If members of the household were enrolled in more than one health plan through the Exchange
- If an Exchange Policy ID changed because an enrollee reported a change to the Exchange that caused a new policy to be issued such as removing the original subscriber (ex., due to divorce, Medicare enrollment, or death)
- If enrollees chose a new plan during the year, (e.g., because of a Special Enrollment Period (SEP) associated with marriage, divorce, adoption, birth, change in Indian status)

- If there are more than five individuals covered by a policy
  NOTE: The additional Forms 1095-A will continue Part II information. Parts I and III will be left blank. The extra pages will come together in the same envelope.

Enrollees need the information on Form 1095-A to complete IRS Form 8962, which they must file with their tax return if they want to claim PTC or if they received premium assistance through APTC. Form 1095-A lists the individuals who were enrolled in a QHP, the QHP premium, and any APTC that was paid on the enrollee's behalf to the issuer. It is important to note that premium amounts reported on Forms 1095-A are not the amount that enrollees are used to seeing on their monthly insurance bill, because they are:

- Reduced for premiums allocated to benefits exceeding EHB.
- Increased by premiums for a stand-alone dental plan allocated to pediatric dental benefits.
- Not reduced for applied APTC.

10.5.1 Form 1095-A Reprints and Corrections

If enrollees want another copy of their Form 1095-A, issuers should direct them to log into their online Exchange account and print their form in the Tax Forms section. If enrollees do not have online accounts, they can create one to view and print their Form 1095-A. Alternatively, reprint requests can be made to the Marketplace Call Center, and enrollees should expect to receive a hard copy of their Form 1095-A in the mail within one to two weeks. Alternatively, enrollees can log into their IRS Individual Online Account to access their Form 1095-A if they have an account set up with the IRS.

Despite CMS's EDA efforts, in some cases, FFE information about enrollees may be incorrect. Enrollees can request corrections be made to their Form 1095-A information by phone or in writing but are strongly encouraged to make requests by calling the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

When enrollees request a change of address or a change in coverage information via the Marketplace Call Center, a Health Insurance Casework System (HICS) case is opened and placed in the Form 1095-A corrections casework queue. Form 1095-A Consumer Disputes caseworkers then research the change request using all available CMS resources, i.e., the FFM Extract, issuer data in the Reconciliation Outbound (RCNO) file, and Form 1095-A to determine if a data discrepancy exists. If the data discrepancy is validated, Form 1095-A correction caseworkers process the change, update the FFE database, and close the HICS case. Finally, the FFE sends issuers IPA's and 834 transactions for all updates processed by the Form 1095-A corrections caseworker. Non-demographic Form 1095-A casework research includes issuer outreach to validate the consumer Form 1095-A dispute.

Enrollee Assistance: If enrollees reach out to their issuers first, and have questions about policy start or end date, covered individual start or end date, or APTC or premium amount, issuers should check issuer records against the Form 1095-A (as reported by the enrollee) and the enrollee's understanding of the correct data. If issuer records match information on Form 1095-A (as reported by the enrollee) but not the enrollee's records of coverage, direct the enrollee to the Marketplace Call Center if they have additional questions.

As outlined in more detail in **Section 10.5.2**, **Form 1095-A Corrections Process: Additional Information,** the FFE evaluates enrollees' assertions that information on Forms 1095-A is incorrect, updates incorrect data, and generates Initial, Corrected, or Voided Forms 1095-A accordingly.

CMS leverages a recurring bi-monthly corrections process to update the FFE database and generate Forms 1095-A and notices. At the conclusion of each cycle, Initial, Corrected and Voided Forms 1095-A are generated and mailed to tax filers, and the data is sent to the IRS to ensure all parties have accurate information.

Enrollees who want to request updates to their Forms 1095-A should call the Marketplace Call Center by early March to maximize the likelihood that they get an update before the tax filing deadline.

10.5.2 Form 1095-A Corrections Process: Additional Information

The Marketplace Call Center representatives will leverage available resources (e.g., standard operating procedures [SOPs], frequently asked questions [FAQs], scripts) to try and address enrollees' Form 1095-A concerns.

Research: If enrollees' concerns are not resolved, Marketplace Call Center representatives will triage the case accordingly and CMS will conduct research to evaluate the information in question. All Form 1095-A Consumer Disputes caseworkers follow CMS-approved processes when conducting research. CMS research process includes:

- Review of FFE data.
- Review of issuer data in the RCNO.
- Review of the enrollee's Form 1095-A data.
- Outreach to issuers email/phone to confirm if issuers' records match data on Form 1095-A, as needed.
- Outreach to enrollees to obtain additional information, as needed.

Enrollee Outreach: If research concludes that an enrollee's Form 1095-A is derived from incorrect data (i.e., data on Form 1095-A does not match what the enrollment record should be, and the enrollee request for a corrected form is approved), Form 1095-A Consumer Disputes caseworkers call enrollees to tell them their request was approved and close the HICS case. The updated data is submitted to the next Form 1095-A Corrections cycle, and Forms 1095-A are generated, posted to the Marketplace account, and mailed to enrollees.

If research concludes that data on an enrollee's Form 1095-A is correct (i.e., data on Form 1095-A matches FFE data sources, and enrollees' requests are denied), Form 1095-A Consumer Disputes caseworkers call enrollees to tell them their request was denied. If the enrollee is satisfied with the CMS decision, the HICS case is closed, and a denial letter is sent to the enrollee for their records. The enrollee should file their taxes with their existing Form 1095-A.

If an enrollee is not satisfied with the decision, they may request the case to be reconsidered. In such cases, CMS Regional Office caseworkers review the Form 1095-A Consumer Disputes caseworker's decision, including collection of additional input from the enrollee and/or issuer as needed, and make a recommendation to the corrections caseworker to either approve the enrollee's request or uphold the denial. The Form 1095-A Consumer Disputes caseworker will again follow up with the enrollee by phone regarding approval or denial of the reevaluated decision and will close the HICS case.

Issuer Outreach: In instances where missing or conflicting information is provided in the Form 1095-A HICS case narrative or when discrepancies exist among FFM, RCNO, and FFM Extract data, the Form 1095-A Consumer Disputes caseworker will utilize a CMS Decision Matrix to determine if

issuer outreach is necessary to resolve the case. Situations that may warrant issuer outreach include (this list is not all inclusive):

- The enrollee's claim does not align with the issuer's RCNO data.
- FFE enrollment data shows the consumer enrolled in overlapping policies.
- The consumer received a grace period due to non-payment of monthly premiums.
- The case involves retroactive termination of a policy.
- The case involves an Unaffiliated Issuer Enrollment (UIE).
- The case is linked to a separate, open Category 2 (Plan and Issuer Concerns) HICS case.

Additionally, issuers may be contacted by a Form 1095-A Consumer Disputes caseworker to:

- Accurately resolve a consumer's 1095-A dispute when internal data sources are unable to provide a determination.
- Collect additional enrollment information directly from the issuer (i.e., policy start and end dates, premium amounts, and APTC) when a decision cannot be made using the information collected from CMS sources, including FFM Extract, RCNO, Forms 1095-A, etc.
- Use the additional information and issuer's input to facilitate Form 1095-A correction decisions.

The Form 1095-A Consumer Disputes casework team performs issuer outreach through email communication (1095aissueroutreach@cms.hhs.gov), file transmission using CMS Electronic File Transfer (EFT), and by telephone (701-264-3017).

- The Form 1095-A Consumer Disputes caseworker generates an encrypted Excel file containing the HICS cases for each affected issuer. Each consumer dispute will have its own tab within the Excel workbook.
- Each tab will contain the consumer's personal information, reason for dispute, and specific questions about the policy, such as start and end dates, APTC, monthly premium, claims, and reason for termination.
- Issuers are responsible for populating all requested fields within each tab and resubmitting the encrypted Excel file to the Form 1095-A corrections caseworker using the same password.

To minimize email traffic, the Form 1095-A Consumer Disputes casework team bundles and transmits Excel files between 5:00 and 6:00 p.m. ET Monday through Friday. Issuers are expected to respond to the standard outreach requests within three business days from receipt of the initial file. An exception to the three-business day requirement is expedited VIP issuer outreach request, which have a one business day requirement. VIP requests will be identified as "Urgent" in the subject line of the email.

Form 1095-A Consumer Disputes caseworkers function as case managers and manage outreach efforts for assigned issuers. This approach promotes a single point of contact between the issuer and the Form 1095-A Consumer Disputes casework team and ensures a quicker response time. If a response is not received from the issuer within the appropriate time frame, the Form 1095-A Consumer Disputes caseworker will escalate the case to CMS for additional assistance.

Most non-demographic Form 1095-A consumer dispute cases go through issuer outreach. To mitigate consumer confusion, CMS does not accept issuer-initiated changes through any EDA method (IC834, Enrollment Data Reconciliation, or disputes) when a correction has been processed for the same policy. When an issuer contests that additional changes or updates are necessary to resolve the 1095-A

discrepancy, the issuer should instruct the consumer to initiate a new request using the 1095-A process.

Correction Cycle Fallout: In rare cases, Form 1095-A files fail to generate successfully (i.e., "fallout") due to errors. CMS conducts research to resolve errors and resubmits the Form 1095-A file back into the next Correction Cycle or manually generates the form (if automatic generation is not possible). This process adds 2–4 weeks to the average case resolution time. Some Form 1095-A fallout will lead to scenarios where the Forms 1095-A are not available in enrollees' online account.

Summary: After requesting a correction, enrollees can expect to receive:

- A phone call from a corrections caseworker within two weeks.
- A hard copy of their Form 1095-A in the mail within approximately 2–4 weeks (add an additional 2–4 weeks for fallout when applicable).
- A denial notice in the mail within:
  - Approximately 2–3 weeks for cases denied without escalation.
  - Approximately five weeks for cases denied and escalated for a second review.

CMS is required to carry out this process and furnish accurate Forms 1095-A for enrollees for seven years after the plan year.

10.6 Impact of Prior-Year Appeals

Prior-year eligibility appeal decisions from the Exchange Appeals Center present a specific challenge to producing an accurate Form 1095-A for enrollees (or appellants) who receive an appeal decision in their favor and choose to have their decision implemented retroactively.

Appeal decisions implemented after March of the subsequent year (once data Enrollment Data Reconciliation and IC834 transactions have concluded for prior-year coverage) require additional handling and care to ensure that individuals receive an accurate Form 1095-A.

The following information is updated from a previously released Section 8.1 of *Bulletin #17 – Effectuation Eligibility Appeal Decisions and Related Enrollments in the FFE*.

10.6.1 Steps to Follow for Prior-Year Appeal Adjudications

1. Upon receipt of a HICS case instructing an issuer to implement a prior-year appeal decision, the issuer should follow the directions in the HICS case narrative.
2. Once an issuer has followed the directions in the HICS case narrative related to a retroactive appeals decision, it should submit these enrollment changes via the ER&R Enrollment Dispute process (see **Section 7.5**, **Issuer Termination Notice** Requirements). These updates will also be noted on the next Pre-Audit File released for the year that the update was made in the FFE. Refer to the *Pre-Audit and Reconciliation Calendar* for delivery dates of each Pre-Audit File, located at https://zone.cms.gov/document/enrollment-data-reconciliation.

FFE updates accepted via the ER&R dispute process will automatically trigger Corrected or Voided Forms 1095-A for retroactive Appeals determinations.

11. Eligibility Changes for the Dually Enrolled or Deceased

11.1 Introduction

Exchange enrollees aren't eligible for financial assistance such as advance payments of the premium tax credit (APTC) and cost-sharing reduction (CSR) if they are eligible for or enrolled in other minimum essential coverage (MEC), such as coverage provided by Medicare Part A or Part C (Medicare Advantage), certain qualifying Medicaid or Children's Health Insurance Program (CHIP) coverage, or certain coverage provided by an employer plan. Enrollees who do not report eligibility for or enrollment in other coverage to the Exchange are at risk of having to repay APTC when they file their annual Federal income tax return and reconcile APTC. While an issuer should not end financial assistance if it believes the enrollee is eligible for or enrolled in other MEC, the issuer is encouraged to reach out to the enrollee suspected of being eligible for MEC to urge the enrollee to report their eligibility or enrollment in other coverage to the Exchange so that the enrollee's eligibility can be redetermined, and financial assistance removed prospectively, if appropriate.

Similarly, if an issuer receives information that an enrollee is deceased, the issuer should direct the qualified individual (QI) or representative to report the enrollee's death through their HealthCare.gov account or by calling the Marketplace Call Center and following the steps in **Section 7.3**, **Termination of an Enrollee's Coverage in the FFE Due to Report of Death**.

A QI is only eligible for financial assistance on one Exchange enrollment. When an enrollee changes from one Qualified Health Plan (QHP) enrollment to another QHP on the Exchange, such as during a Special Enrollment Period (SEP), the Exchange automatically terminates the enrollee's coverage under the first QHP, if the enrollee uses their existing Exchange account. If an enrollee, an assister, or an agent or broker (A/B) creates a new enrollment without using the existing account, a dual Exchange enrollment can be created. Other dual enrollments are created inadvertently when a dependent on one application/enrollment creates a new application and enrollment without the original application contact ending coverage for the enrollee on the initial policy or when parents in separate households enroll the same child on each parent's policy. Because these dual Exchange enrollments are inadvertent and financial assistance may only be applied to one policy, the Exchange conducts monthly overlap cleanups that end the overlapping or dual coverage. Issuers can find enrollments cancelled for duplicating other Exchange enrollments by checking to see if the policy is flagged for overlaps on the regularly scheduled monthly Pre-Audit File.

Issuers should review records flagged with the overlaps indicator on the Pre-Audit File to ensure proper alignment of enrollment records based on the enrollment transactions initiated by the enrollee, which may necessitate termination or cancellation of impacted policies. The flag will be set only on the records cancelled or terminated on the Federally-facilitated Exchange (FFE) as part of the overlapping enrollment cleanup—the subsequent records that led to the overlap are not flagged in the file. The overlapping or duplicate coverage may be with a different issuer, which will be conveyed by the overlap's indicator value.

Issuers who observe dual Exchange enrollment because they are the issuers of both policies may use the Enrollment Data Reconciliation process to eliminate the overlap or encourage the enrollee to contact the Exchange.

11.2 Periodic Data Matching

Enrollees who are eligible for or are enrolled in MEC Medicaid, CHIP, or Medicare are ineligible for APTC/CSR to help pay for their Exchange plan premium and covered services.

The FFE proactively checks trusted data sources to redetermine eligibility for financial assistance for those found dually enrolled in Exchange coverage and other MEC and to determine if an enrollee has become deceased during a plan year. As described at 45 CFR 155.330(d), Periodic Data Matching (PDM) includes the process by which the Exchange[82] periodically examines available data sources to determine whether enrollees who are enrolled in Exchange coverage with APTC/CSR are concurrently enrolled in MEC Medicaid or CHIP[83] or Medicare Part A or Part C, otherwise known as Medicare Advantage. Exchanges are required to conduct PDM at least twice per year. State-based Exchanges (SBEs) that have implemented a fully integrated eligibility system with their respective state Medicaid programs, that have a single eligibility rules engine that uses Modified Adjusted Gross Income (MAGI) to determine eligibility for APTC, CSR, Medicaid, CHIP, and the Basic Health Program (BHP), if a BHP is operating in the service area of the Exchange, are deemed in compliance with the Medicaid/CHIP PDM requirements and, if applicable, BHP PDM requirements.

11.3 Medicaid/CHIP PDM

After conducting data matching to identify QHP enrollees who are receiving APTC and who also appear to be enrolled in Medicaid or CHIP, the Exchange sends an initial warning notice to the application contact of the affected enrollees. The application household contact and/or affected enrollees have 30 days from the date of the notice to respond. The notice instructs them to return to the Exchange by the date listed in the notice to either A) update their application by indicating they are not enrolled in Medicaid or CHIP, if applicable; or B) end Exchange coverage with APTC/CSR if they are enrolled in Medicaid or CHIP.

At least 30 days after sending the initial notice, the Exchange sends a second, final notice to the application household contact of affected enrollees who did not take appropriate action by the deadline, informing them that the Exchange will be ending any financial assistance. Exchange coverage for affected enrollees will continue without financial help and they will need to end their Exchange coverage if they no longer wish to be enrolled in that coverage at full cost. If they choose to remain in full-cost Exchange coverage, they should notify their state Medicaid or CHIP agency of their Exchange enrollment; they may no longer be eligible for CHIP. For unaffected household members, Exchange coverage may continue, and the Exchange will redetermine their eligibility for APTC/CSR, if applicable. The issuer will receive notice of these changes through an enrollment transaction, typically sent as a Maintenance 834 (M834) transaction that removes financial assistance for the dually enrolled member.

[82] This includes the FFE and SBEs using the Federal eligibility and enrollment platform.

[83] Most Medicaid is considered MEC; some forms of Medicaid that cover limited benefits, like Medicaid that only covers emergency care, family planning, or pregnancy-related services, are not considered MEC. For more information on what Medicaid programs are considered MEC, visit https://www.healthcare.gov/medicaid-limited-benefits/. Most CHIP is considered MEC.

11.4 Medicare PDM

The Exchange also periodically examines data sources to determine whether individuals receiving Federal financial assistance have been determined eligible for or enrolled in MEC Medicare.[84] Individuals dually enrolled in MEC Medicare and Exchange coverage are ineligible for financial assistance. When filing their Federal income tax return, enrollees may have to pay back all or a portion of the APTC paid on their behalf for months they had both Exchange coverage and MEC Medicare.

Individuals found to be dually enrolled must be notified of the determination pursuant to 45 CFR 155.330(d) and (e), and if the enrollee does not respond within 30 days of the date of the notice, the Exchange must take action to end APTC and CSR or Exchange coverage, depending on the consumer(s)' preference. Medicare PDM notices include the names of individuals who were found to be dually enrolled in MEC Medicare and Exchange coverage, a recommendation and instructions to end Exchange coverage with APTC/CSR to those dually enrolled individuals, and where to find contact information to confirm Medicare enrollment or if they have any questions about Medicare. Consumers are asked on their Exchange application if they would prefer to have their coverage ended if they are found dually enrolled in coverage, as opposed to just having their APTC ended.

Currently, if the FFE identifies QHP enrollees as dually enrolled during the PDM process and the enrollees agreed upon enrollment to allow the FFE to terminate their coverage if they are found to be enrolled in other qualifying coverage, such as MEC Medicaid/CHIP or MEC Medicare (via the FFE termination attestation application question), they will have their Exchange coverage terminated. For enrollees who do not provide consent for their Exchange coverage to be terminated, the FFE instead ends their APTC/CSR. As outlined in 45 CFR 155.330, the FFE sends out a notice and enrollees have 30 days to respond before the FFE takes any action. Also, the FFE does not redetermine eligibility for APTC/CSR for enrollees who voluntarily permit the FFE to end their Exchange coverage if later found to be enrolled in Medicare. Issuers will be informed of necessary changes to enrollee(s)' coverage via the current 834 transaction process and guidance.

11.5 Medicare Anti-Duplication

Under Section 1882(d)(3)(A)(i)(I) of the Social Security Act (SSA), it is illegal to knowingly sell or issue an Individual Market Exchange QHP (or an individual market policy outside the Exchange) that duplicates[85] Medicare or Medicaid benefits a beneficiary is entitled to. This prohibition does not apply to a renewal of coverage under the same policy or contract of insurance. This prohibition also does not apply to employer coverage.[86]

An issuer that receives a new Exchange enrollment for a QHP that "duplicates" coverage for an individual that the issuer has knowledge is entitled to Medicare Part A or enrolled in Medicare Part B should cancel the QHP coverage with the Additional Maintenance Reason Code (AMRC) CANCEL-ANTIDUPLICATION before the coverage is effectuated (binder paid and coverage has started). QIs not entitled to Medicare Part A and not enrolled in Medicare Part B but whose QHP coverage is non-renewed by the issuer because they share a policy with an enrollee who is so entitled or enrolled will

[84] Medicare Part A (hospital insurance) and Medicare Part C (Medicare Advantage) are deemed MEC, whereas Medicare Part B (medical insurance) or D (prescription drug coverage) alone are not considered MEC.

[85] See Section 1882(d)(3)(A)(iv) of the SSA (providing that a health insurance policy, other than a Medicare supplemental policy, that provides benefits payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to "duplicate" for purposes of the Medicare anti-duplication provision).

[86] See Section 1882(d)(3)(C) of the SSA.

generally be eligible for an SEP. An issuer may not terminate a QHP policy of someone who is so entitled or enrolled during the plan year because the issuer gains knowledge of the duplication of coverage after effectuation but must non-renew the QHP coverage effective December 31 if the re-enrollment plan is a different policy or contract of insurance and the new coverage duplicates Medicare or Medicaid benefits to which the enrollee is entitled (see also **Section 3.4.8**, **Medicare Enrollment and Non-Renewals**).

11.6 Deceased Enrollee PDM

The FFE takes action to end coverage for consumers who are both 1) identified as deceased via a periodic data match through the Exchange's trusted data source and 2) enrolled in a QHP through the Exchange in accordance with 45 CFR 155.330. For these consumers, the FFE terminates their Exchange coverage retroactively, effective as of the date of the consumer's death if it occurred during the plan year or effective on the start date of their current-year coverage if date of death occurred before current coverage started.

Since 2019, the Exchange has ended Exchange QHP coverage for consumers who are enrolled in Exchange QHP coverage and who have been identified as deceased through periodic data checks. This is accomplished by matching Exchange enrollment data against the Social Security Administration's Death Master File, which the Social Security Administration provides to CMS on a weekly basis.

After a consumer is identified as both deceased and enrolled in QHP coverage, the Exchange generates a Death PDM initial estate warning notice, addressed to the decedent's estate (i.e., "to the estate of…"), with instructions for affected consumers. Due to the sensitivity of death information and to protect the Exchange from potentially fraudulent activity, notices are only mailed via United States Postal Mail at this time, even if the consumer's stated preference was electronic delivery only. Notices will not be posted to the My Account section of the consumer's online Exchange account.

After receiving the Death PDM initial warning notice, consumers are instructed that no action on their part is required if the reported information is correct. However, consumers have 30 days to report that they are not deceased if the Exchange erroneously identified them as deceased due to a data error in the Death Master File. To report they are not deceased, consumers can call a special outreach hotline established by CMS and leave their contact information. These consumers receive special notice outreach from CMS in order to 1) confirm that they are not in fact deceased and 2) provide guidance on how to correct their information with Social Security Administration.

After the 30-day window expires, the Exchange acts to end QHP coverage for Exchange enrollees who were identified as deceased and have not reported otherwise. QHP coverage is terminated retroactively to the reported date of death as received from Social Security Administration's Death Master File. The Exchange will ensure that appropriate actions are taken to make necessary adjustments to APTC, CSR, premiums, claims, and user fees, including by instructing Exchange issuers to refund premium payments to the deceased's estate for QHP coverage retroactively terminated due to death.

Due to functionality limitations, the Exchange only undertakes this process for deceased enrollees in single-member applications. CMS is currently exploring IT functionality developments to allow the Exchange to remove deceased enrollees from applications in which multiple members are enrolled.

Issuers will be informed of necessary changes to enrollees' coverage via the current 834 transaction process and guidance. Issuers may receive either a TERM-PDM or a CANCEL-PDM code. Consumers who had an active enrollment in coverage will be designated with the TERM-PDM code,

with the termination date being the date of the member's death. Consumers who had a policy in the initial status will be designated with the CANCEL-PDM code, where the cancel date will be the policy effective date.

12. Addressing Individual and Issuer-Reported Unauthorized Enrollments and Issuer-Reported Fraudulent Enrollments

12.1 Introduction

The Federally-facilitated Exchange (FFE) receives complaints alleging fraud and/or misrepresentations from both individuals and issuers regarding suspect enrollments into Qualified Health Plans (QHPs) offered through the FFE or State-based Exchanges on the Federal Platform (SBE-FPs). CMS, as administrator of the FFE and the Federal Platform for the SBE-FPs, takes each complaint seriously, and the Center for Consumer Information & Insurance Oversight (CCIIO) works closely with the Center for Program Integrity (CPI) to review and respond to these complaints through two distinct processes. The first (unauthorized enrollment, or UE) process deals with complaints from individuals who call the Marketplace Call Center (or an issuer directly) to report alleged misconduct by an individual other than the enrollee, resulting in UEs or unauthorized plan switches (UPSs). This process includes reports from an issuer alleging that an enrollee(s) was enrolled in a plan without their knowledge or consent. The second (rescissions) process focuses on information submitted to CMS by issuers whose internal analyses or investigations revealed possible enrollment fraud or the intentional misrepresentation of material facts during the application and enrollment process. Each of these processes is described in the following subsections.

Both types of misconduct could indicate that an issuer's downstream entity, such as an agent or broker, violated consent documentation requirements in 45 CFR 155.220(j)(2)(ii)(A) or (iii)(A). Issuers are responsible for the noncompliance of their downstream entities (45 CFR 156.340(a)(2)).

12.2 Individual Complaints Alleging UEs

The Marketplace Call Center receives calls from individuals reporting that they are enrolled in Exchange plans they did not know about or authorize. In many cases, the individuals state that they only learned they were enrolled in a QHP through the FFE when they received a communication from the Exchange, an issuer, or the Internal Revenue Service (IRS), which requires that advance payments of the premium tax credit (APTC) be reconciled with annual Federal income taxes before refunds can be processed. In some cases, the individuals indicate that they already have other health insurance and do not need or want an Exchange plan.

As relevant here, regulations specify that the Exchange must permit an enrollee to cancel a policy under the following circumstances:

- The enrollee demonstrates to the Exchange that their enrollment in a QHP through the Exchange was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or the Department of Health & Human Services (HHS), its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. For purposes of this requirement, misconduct includes the failure to comply with applicable standards under 45 CFR Parts 155 and 156 of this subchapter or other applicable Federal or state requirements as determined by the Exchange."

- The enrollee demonstrates to the Exchange that he or she was enrolled in a QHP without their knowledge or consent by any third party, including third parties who have no connection with the Exchange, and requests cancellation within 60 days of discovering of the enrollment.

In both cases, an enrollee must request cancellation within 60 days of discovering the enrollment.

12.2.1 Operational Process for Cancelling UEs Reported by Consumers

All individual complaints that are classified as possible UEs are sent to issuers through the Health Insurance Casework System (HICS).[87] The complaints are categorized as Category 2 (Plan and Issuer Concerns) with the Subcategory Cancellation/Termination Request or Alleged Unauthorized Enrollment. Issuers should examine the case to determine if the following three UE criteria are met:

1. The individual's premium is covered 100 percent by APTC or, if not 100 percent, any portion of the premium that is the responsibility of the enrollee was NOT paid, **or** the issuer has evidence that premiums were paid by a third party, such as the agent or broker who enrolled the consumer.
2. No claims have been filed for any of the enrollees on the policy, **or** the case narrative indicates, or the issuer otherwise knows, that the enrollee is enrolled in another form of coverage such as Medicaid or employer-sponsored coverage.[88]
3. The issuer has had no contact from the enrollee about their policy or benefits, including emails or calls to customer service, **or** the enrollee only contacted the issuer within the 60 days prior to contacting the Exchange to cancel coverage or report they did not know about or consent to the enrollment.

If an issuer finds that all three of the criteria have been met, the FFE will consider this corroboration that the individual did not have knowledge of, or did not consent to, the enrollment and that cancellation of coverage is appropriate.

If one or more of the criteria are not met, the issuer may not grant the consumer's request to cancel coverage and should document the resolution in HICS. The resolution of all HICS cases must be thoroughly documented per 45 CFR 156.1010(g)(2). Once the issuer has determined whether the policy will be cancelled, that information **must be documented** in HICS by using the Outcome of Resolution dropdown. The Outcome of Resolution choices should be used as follows:

- **Approved cancellation** – The issuer should select the dropdown choice ***Issuer has adjusted its record, in whole or in part, in accord with the request/directive***.
- **Denied cancellation** – Issuers who are not permitted to cancel the policy should choose one of the following dropdown choices that indicates why the policy cannot be cancelled:
  - ***Issuer did not cancel/terminate as requested, consumer paid premiums.***
  - ***Issuer did not cancel/terminate as requested, consumer had paid claims.***
  - ***Issuer did not cancel/terminate as requested, consumer contacted the Issuer*** (for reasons other than to cancel their policy).

[87] Issuers reporting UEs using HICS, should follow this guidance: UE Finder File Round 9 Instruction Letter and HICS Casework and UEs using HICS presentation.

[88] For example, an issuer may be aware that an enrollee was enrolled in other coverage because that enrollee was also enrolled in a Medicaid plan offered by the same issuer. Claims may be filed on a policy that was not authorized by the consumer because a provider detected the QHP through an eligibility system and billed the issuer without the enrollee's knowledge. This is especially likely for consumers enrolled in Medicaid, which is a payer of last resort.

- ***Issuer is not permitted to make any requested change(s) according to CMS/issuer policy*** (if there are multiple criteria that were not met).
- ***Issuer was unable to contact consumer/provider***

No other Outcome of Resolution choices may be used.

12.3 Issuer Reports of Suspected UEs

Issuers may become aware of UEs that were not reported to the Marketplace Call Center, such as through consumer complaints to the issuer alleging a UE or through their own investigations or data analyses. Issuers may also receive requests from CMS to investigate a set of policies as potential UEs for potential Exchange initiated termination, in accordance with the FFE's authority under 45 CFR 155.430(b)(2)(vi), which permits an Exchange to terminate a QHP enrollment when the enrollee was enrolled without his or her knowledge or consent by a third party.

12.3.1 Operational Process for Cancelling UEs Identified by Issuers

To facilitate reporting of UEs, CMS has established a process for issuers to report these directly to CMS, without the need for the enrollee to call the Marketplace Call Center. Issuers who believe they have identified UEs should first check to see whether the policies meet the three criteria described in **Section 12.2.1**, **Operational Process for Cancelling UEs Reported by Consumers**, with the exception that for issuer-reported UEs, the policies cannot have claims filed.[89] As with individual reports of UEs, if any of the criteria are not met, the policies cannot be cancelled (unless cancellation is otherwise permitted).

In addition, if the suspected UEs did not originate with a complaint from an enrollee, the issuer must make at least two attempts to contact each enrollee using different methods of communication (phone, email, mail, etc.).[90] Issuers may also submit the list of suspected UEs to CMS after confirming that the three criteria have been met, but before the required 30-day notice period has concluded. If the enrollee responds indicating that the enrollment was authorized, then the issuer should not include those policy(ies) in the list reported to CMS, or if already submitted, inform CMS that those policy(ies) should not be cancelled. If the enrollee responds indicating that the enrollment is unauthorized, or the enrollee does not respond within 30 days after the second notice is sent,[91] the issuer should fill out the Issuer-Reported UE Template. The spreadsheet should be filled out with the following information:

- Exchange policy and application IDs for each enrollment the issuer believes to be a UE.
- The state and plan year associated with the enrollment (multiple states and plan years can be entered if necessary).[92]

[89] Unlike reports of UEs that originate with consumers through the Marketplace Call Center, issuer-reported UEs do not necessarily originate with a complaint from the consumer, who could provide information on whether they were enrolled in another form of coverage. As a result, although CMS may approve exceptions on a case-by-case basis, CMS expects that most issuer-reported UEs will be for policies without filed claims.

[90] Although the contact information for an enrollee may be invalid (e.g., returned mail or an email bounce-back), the issuer must still attempt to contact the enrollee.

[91] For especially large sets of suspected UEs, issuers can submit the spreadsheet to CMS before the 30-day notice period has ended, which will enable CMS to complete the Enrollment Resolution and Reconciliation (ER&R) check and provide preliminary approval once the 30-day period has ended.

[92] In general, CMS expects that issuer-reported UE submissions will be for the current and previous plan year. For submissions further back, issuers should include an explanation of why the UEs were only recently identified.

- Confirmation that each of the three UE criteria have been met.
- The date(s) the issuer attempted to contact the enrollee to notify them of the potential UE.
- The contact information for the person submitting the spreadsheet.
- If applicable, additional information that the issuer would like to include for CMS awareness.

The completed spreadsheet should be emailed to issuer_reported_ues@cms.hhs.gov, along with a brief explanation of how the UEs were identified, and the issuer's AM should be copied. The submitter will receive a reply from CMS (NoReply_IssuerUE@cms.hhs.gov) acknowledging receipt, and providing a case number associated with the request.

Once all the necessary information has been provided, CMS will review the request to confirm that the three UE criteria have been met. CMS will also conduct an internal analysis to determine whether any indicators of consumer awareness of the policy can be identified via ER&R. If no indicators are identified, the policies will be cancelled by CMS (following the process in **Section 12.4.1**, **Cancelling Consumer-Reported UEs and Approved Issuer-Reported UEs**) as soon as the 30-day notice period has passed. If any indicators are found,[93] the issuer will receive a reply indicating that those specific policies will not be cancelled.

12.3.2 Reports of Mail Going to the Wrong Address

From time to time, the Marketplace Call Center and issuers receive complaints from the recipient of FFE-related mailings that the enrollee does not live at that address. Because mail going to the wrong address is often the result of an unintentional error, such as the enrollee accidentally entering a different address, issuers should not automatically assume that these suggest there was a UE. Instead, the issuer should attempt to contact the enrollee, or their agent or broker if applicable, using the contact information available (such as phone or email) to encourage the enrollee to update their address with the Marketplace. If an issuer has additional evidence to suggest the enrollment was unauthorized, the policy can be reported as a potential UE (see **Section 12.3**, **Issuer Reports of Suspected UEs**). If the issuer knows the enrollee is no longer living in their service area, the issuer can non-renew the enrollee's coverage at the end of the plan year.[94]

12.4 Implementing Cancellations for UEs

Once CMS determines that an enrollment was a UE, there are two methods by which UEs are cancelled, based on whether the UEs originate from a consumer complaint in HICS or issuer reports of suspected UEs not reported to the call center.

12.4.1 Cancelling Consumer-Reported UEs and Approved Issuer-Reported UEs

In September 2025, the FFE began cancelling UEs reported through HICS via outbound 834 to issuers using an Additional Maintenance Reason Code (AMRC) of CANCEL-FRAUD. Issuers should review and resolve UE HICS cases in accordance with the guidance in **Section 12.2.1**, **Operational Process for Cancelling UEs Reported by Consumers**. If the issuer resolves the case and selects the Outcome of Resolution option indicating an approved cancellation, all policies associated with the application ID and issuer ID in the HICS case will be cancelled through the weekly script, which processes cancellations via outbound 834 with an AMRC of CANCEL-FRAUD. Issuers who do not wish to

[93] Such as the enrollee calling the Call Center to ask about their enrollment.
[94] In accordance with 45 CFR 147.106(b)(5).

cancel all policies associated with the application ID and issuer ID in the HICS case should select the ***Other*** Outcome of Resolution and indicate the policies they intend to cancel due to fraud in the case notes. Issuers who wish to cancel some, but not all, policies are required to cancel the applicable policies, preferably via IC834 using an AMRC of CANCEL-FRAUD (see additional information regarding issuer cancellations in **Section 12.4.2**, **Cancelling UEs via EDA**).

Issuers should be aware that any future-year policy in a passive status that is connected to a current-year policy associated with a cancelled UE will be automatically cancelled. The issuer does not need to request a HICS case for a future-year passive enrollment in this scenario, nor do issuers need to manually cancel the future-year passive enrollment.

Starting in August 2026, the FFE began cancelling approved issuer-reported UEs via outbound 834 to issuers using an AMRC of CANCEL-FRAUD, as well. If applicable, issuers should notify CMS once the 30-day notice period has passed. The FFE will then cancel all approved UEs via outbound 834. HICS cases will not be created for issuer-reported UEs.

12.4.2 Cancelling UEs via EDA

For consumer reported UEs where the issuer determines that some, but not all, policies associated with the application ID and issuer ID in the HICS case should be cancelled, the issuer must cancel the applicable policies. The preferred method to do so is by submitting an Inbound 834 (IC834) with an AMRC of CANCEL-FRAUD. The policy must also be submitted as a cancellation due to fraud using the appropriate Cancellation Reason Code of 9 on the monthly Reconciliation Inbound (RCNI) file. Issuers must ensure the cancellation is updated on the FFE following submission of the IC834 CANCEL-FRAUD transaction by checking the System of Exchange Enrollment Data (SEED). If the policy is not updated via IC834 due to a technical issue, issuers are to check SEED again after the next reconciliation cycle to determine if the cancellation has been applied. If the policy is still active on the FFE, the issuer must submit an Enrollment Dispute to ensure the policy is appropriately cancelled on the FFE.

While IC834 is the preferred method of cancellation that provides the fastest relief to enrollees, issuers can use the Enrollment Dispute process to cancel enrollments. For policies within the current reconciliation year, issuers should use the Rejected Enrollments tab on the Enrollment Dispute Form. For prior-year cancellations, issuers should use the Initial Premium Paid Status dispute type on the Dispute Discrepancy tab of the form. Once the policy is cancelled in the FFE, the FFE recoups any APTC and makes adjustments for user fees.

It is important to submit an AMRC of CANCEL-FRAUD **even if the policy is already terminated for non-payment** because many of the individuals had APTC that covered all or some of their premium payments, resulting in Forms 1095-A being generated and shared with the IRS showing subsidy amounts for any month(s) of the year in which APTC payments were made. To relieve individuals of tax liabilities for UEs, a corrected Form 1095-A must be created, which can only happen once the policy is cancelled back to the effectuation date.

Finally, as with any HICS case, regulations at 45 CFR 156.1010 require that **the issuer contact the enrollee to report the resolution of the case** whether the policy is cancelled or remains in effect. If issuers have questions about this process, they should email the Marketplace program integrity mailbox at MarketplaceIntegrity@cms.hhs.gov.

12.5 Individual Complaints Alleging a UPS

Enrollees who believe that they were switched to a different Exchange plan without their authorization should report this to the Marketplace Call Center. These cases are distinct from UEs because the enrollee did intend to enroll in Exchange coverage and wants to remain enrolled in their desired plan, but that plan was switched without their consent. Enrollees may also submit such complaints to the issuer directly, and in these cases, the issuer must direct the consumer to contact the Marketplace Call Center. These cases cannot be submitted directly to CMS via the issuer-reported UE process (outlined in **Section 12.3**, **Issuer Reports of Suspected UEs)**.

Once the UPS is reported to the Marketplace Call Center, the call center representative will create a HICS case, which will be transferred to the issuer. The issuer should contact the enrollee to confirm the desired policy (if the issuer is unable to determine the desired policy), reinstate the consumer in that policy in the issuer's internal systems, and maintain accumulators, such as maximum-out-of-pocket and deductibles. Issuers can use Enrollment Data Alignment (EDA) to cancel the undesired policy and reinstate the desired policy for cases in which the enrollee was switched to a different plan within the same Health Insurance Oversight System (HIOS) ID. For a cross-HIOS switch, the issuer should submit a dispute using the Enrollment Dispute Form, which is available on CMSzONE at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation. CMS will perform a monthly data cleanup to cancel the undesired policies and reinstate the desired policies. Please note that issuers who are losing enrollees will be notified on the Pre-Audit File and should take the following actions:

- The issuer of the plan that is being cancelled can identify this type of cancellation via the overlap indicator, a Cancellation Reason Code of 9 (Fraud), and a source code of 5.
- The issuer of the plan that is being cancelled due to the reinstatement must update their enrollment system and continue to submit the policy as cancelled on their RCNI with the Cancellation Reason Code of 9 (Fraud).

The issuers gaining/maintaining the enrollee's coverage should review the Semi-Monthly Detailed Report from the ER&R contractor to identify reinstatements that cannot be processed and take the necessary action for resolution. Please note that it is important that issuers send enrollees all required termination notices with the termination reason regardless of the cancellation source (IC834, reconciliation, overlaps). The termination notice may be the first time the enrollee learns that the desired plan has been cancelled and that the enrollee needs to report a UPS. For additional information on termination notices, see **Section 7.5**, **Issuer Termination Notice Requirements**.

12.6 Reporting Enrollments Associated with Consumer Misconduct: Elements of an Appropriate Rescission of QHPs

Issuers of individual health insurance coverage,[95] including QHPs offered through an Exchange, may only rescind such coverage when the individual[96] (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, as prohibited by the terms of the plan or coverage. The FFE

[95] The prohibition on rescissions also applies to group health plans, health insurance issuers offering group health insurance coverage, and health insurance issuers offering individual health insurance coverage outside the Exchange. See 45 CFR 147.128. However, this document is addressed to individual market QHPs offered through an FFE about what the FFE may rely on to determine whether a rescission is appropriate.

[96] The subscriber on the policy.

requires that QHP issuers demonstrate that a rescission is appropriate, using the procedures described in this section, before rescinding coverage.[97]

QHP issuers wishing to send CMS a rescission request should download the Rescission Request Template. The issuer should fill out the form as completely as possible, encrypt it to protect personally identifying information, and send the form to their Account Manager, copying the CPI mailbox at Marketplaceintegrity@cms.hhs.gov. The Account Manager will review the request for completeness, request additional information from the issuer if necessary, and reject requests that are incomplete or do not meet the basis for a rescission. Once satisfied with the issuer's submission, the Account Manager will add the date of their approval to the request form and notify CPI of the approval. CMS staff will review completed requests and aim to respond to the issuer with a written, electronic communication approving or denying rescission within 30 days. Issuers with pending submissions may contact their CMS Account Managers for a status update. Any agent or broker (A/B) identified as having performed an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, may be investigated by CPI and, if warranted, may have their FFE agreements suspended or terminated.

Issuers with policies approved for rescission must provide 30 days' advance written notice to the subscriber whose policy is being rescinded, as required in 45 CFR 147.128(a). Notices may be sent to the subscriber's FFE mailing address, although issuers may use residential addresses and/or email in addition. If within the 30-day notice period prior to the rescission becoming effective, the enrollee communicates to the QHP issuer that they want to remain in the coverage that would be rescinded, and demonstrates to the issuer that there was no act, practice, or omission that constituted fraud, or any intentional misrepresentation of a material fact, that should give rise to the pending rescission, the QHP issuer must not rescind the coverage.

For current plan year policies approved by CMS for rescission, the issuer should submit an IC834 with Maintenance Type Code (MTC) 024, MRC 07, and AMRC CANCEL-RESCIND. Issuers can typically utilize the IC834 process until late March to late May (subject to change each year) of the following plan year. Issuers must submit the rescinded policy during monthly Enrollment Data Reconciliation as well, using Cancellation Reason Code 14 (CANCEL-RESCIND).

For prior-year policies approved by CMS for rescission, the issuer must submit an Enrollment Dispute through the ER&R contractor using the Discrepancy Dispute tab of the Enrollment Dispute Form. The issuer can either set the end date to equal the start date of the policy using the Prior Year – End Date dispute type or use the Initial Premium Paid Status dispute to cancel the policy. Account Manager approval is required for all prior-year disputes submitted on or after May 1 of the following year, except when there is a supporting HICS case.

Once properly rescinded, the issuer may reverse claims and refuse additional claims filed for the rescinded policy. CMS recoups APTC paid for that period through policy-based payment (PBP) just as for any other retroactively cancelled policy.

In addition, issuers may rescind again coverage for enrollees whose coverage was previously rescinded, without prior approval from CMS, when the following conditions are met:

[97] Per 45 CFR 155.430(b)(2)(iii), Exchanges have the option to require that QHP issuers demonstrate, to the reasonable satisfaction of the Exchange, that rescission is appropriate.

- The re-enrollment giving rise to the desired recission occurs within six months of the date CMS approved the previous rescission.
- The desired recission is on the same basis as the previous decision.[98]
- The issuer notifies CMS of the cancellation via an email to MarketplaceIntegrity@cms.hhs.gov with the application and policy ID(s) of the rescinded enrollment.
- The issuer sends the required 30-days' advance written notice to the enrollee prior to rescinding coverage.[99]

For re-enrollments giving rise to a desired recission that occurs more than six months after the date a previous rescission is approved, issuers may resubmit the original spreadsheet, with an indication that the same enrollee(s) re-enrolled, and the information that resulted in the original rescission has not changed.

Issuers have asked for examples of information the FFE would consider in determining whether it is appropriate for an issuer to rescind coverage under a QHP offered through the FFE. Although the FFE is unable to give an exact formula for an approved rescission, the elements listed below are meant to be a guide to QHP issuers for gathering evidence to support the appropriateness of any rescission request. CMS will consider the totality of the evidence submitted by an issuer to determine whether rescission is appropriate.[100] As a result, issuers are encouraged to submit any information that may be relevant to assist CMS with their review.

Demonstrating intentional misrepresentation of a material fact generally requires showing that: the information was false; the individual (or a person seeking coverage on behalf of the individual) intended to provide such false information; and the individual used such false information to obtain coverage for which they were not eligible.

Finally, QHP issuers must demonstrate a good faith effort to communicate with the enrollee, using all available methods of contact, to give the enrollee an opportunity to rebut the allegations of fraud or intentional misrepresentation of a material fact. Attempts to contact the enrollee (whether successful or unsuccessful) should be documented in the issuer's submission.

12.6.1 Falsity of Information

The issuer must demonstrate that the enrollee (or a person seeking coverage on behalf of the enrollee) provided information that was false. The following are examples of information that could be presented to demonstrate the falsity of information presented to the issuer:

- **False residency address**: Evidence that an enrollee's residency address is false could include:
  - An address at which the enrollee could not have lived, such as at a business that does not permit somebody to reside there.
  - A single address listed for an unreasonable number of enrollees.

[98] For example, if rescission was granted on the basis that the enrollee did not live in the state in which they applied for coverage at the time of enrollment, it must still be true (to the issuer's knowledge) that the enrollee was not living in that state when they re-enrolled.

[99] 45 CFR 147.128(a)

[100] Please note that CMS also considers evidence to which issuers may not have access. For example, when reviewing an issuer's request for rescission, evidence that an enrollee completed applications in several different states simultaneously will be considered, which may support an issuer's allegation that the enrollee intended to provide false information when they applied for coverage.

- An address associated with known fraud in the past.
- Address is that of the facility at which the enrollee is receiving treatment on a temporary basis.
- A statement from the property owner or resident that the enrollee is unknown to the owner or resident and did not live at the address at the time of enrollment nor during the plan year.
  - To support this, CMS would generally require a record, made in the normal course of business, which supports the property owner's or resident's claim that the enrollee did not live at the reported address at the time of enrollment.
- A statement from the enrollee that they did not live at the address at the time of enrollment nor during the plan year.

- **Suspicious pattern of enrollment**: Evidence indicating that an enrollment may have been submitted falsely without the enrollee's full knowledge or consent[101] could include:
  - Suspicious patterns of enrollment involving licensed or unlicensed brokers.
  - Suspicious third-party premium payments, such as:
    - Payments from an A/B.
    - Payments for an unreasonable number of enrollees from a source unrelated to the enrollees.
    - Payments that are made with gift cards.
  - A statement from the enrollee that they were directed to enter certain false information on their application or that they were unaware of the information being submitted on their behalf by a third party.
  - Enrollment for a deceased enrollee – The QHP issuer can demonstrate that the enrollee was deceased at the time of enrollment by matching the member name and Social Security Number (SSN) against the Social Security Administration's Death Master File (to prevent improper cancellation for enrollees with mistyped SSNs and surviving family members who have inherited the deceased's SSN during a Change in Circumstance [CIC], aka "subscriber inheritance") and that the enrollment was not effectuated retroactively after the enrollee's death.
- **Suspicious claims**: Evidence that an enrollee is receiving or has received treatment that corresponds to a known pattern of fraud, which can help support an issuer's claim that an enrollee's submission of false information was intended to gain access to a plan for which the enrollee was not eligible:
  - Since evidence of a specific type of treatment, by itself, seldom (if ever) would be evidence of fraud, an issuer would need to provide evidence (to the satisfaction of the FFE) that the enrollee was not receiving the billed treatment or was not entitled to the insurance policy. An example is sober-home schemes in which enrollees are enrolled in plans they are not eligible for by *intentionally* falsifying material information on the applications in order to gain access to policies with generous out-of-network benefits and low out-of-pocket costs.

12.6.1.1 Examples

Example 12A: An issuer submits a rescission request for an enrollee who the issuer believes did not

[101] If the issuer believes the enrollment was submitted without the enrollee's knowledge or consent, and all three UE criteria are met, the issuer should instead submit the enrollment to CMS using the issuer-reported UE process.

reside at the address listed on the enrollee's application at the time of enrollment. The issuer contacts the owner of the property, who confirms and provides evidence that the enrollee was not living there on the date they applied for coverage. If the issuer also attempts to contact the enrollee to provide them with an opportunity to rebut this information, and the enrollee fails to do so, the issuer has demonstrated falsity of information.

Example 12B: An issuer submits a rescission request for an enrollee, on the basis that the enrollee does not currently live in the issuer's service area. The issuer contacts the enrollee, who explains that they were living in the issuer's service area at the time they enrolled but subsequently moved out of state. The issuer does not submit any additional evidence to demonstrate that the enrollee resided outside their service area at the time of application. Because the issuer has not demonstrated that the enrollee provided false information at the time of application, CMS will likely deny the request for rescission, but the issuer may encourage the enrollee to report the change of address to the Marketplace and may non-renew the enrollee's coverage at the end of the plan year if the enrollee still lives outside the issuer's service area at that time.

12.6.2 Intent

The issuer must demonstrate that the enrollee (or a person seeking coverage on behalf of the enrollee) intended to provide information that was false. The following are examples of facts that could be presented to demonstrate the intention of the enrollee (or someone acting on the enrollee's behalf) to provide false information. One of these examples alone may not be sufficient to show intent, but multiple examples may indicate intent. Examples include:

- **Enrollee corroboration**: The issuer communicates with the enrollee in person, by phone or by mail, and the enrollee either:
  - Indicates that they intended to provide misinformation.
  - States that a third party entered into the enrollment without the enrollee's full knowledge and the enrollee does not want the coverage the issuer is seeking to rescind.

12.6.2.1 Examples

Example 12C: As in Example 12A, an issuer submits a rescission request for an enrollee whom the issuer believes did not reside at the address listed on the enrollee's application at the time of application. The issuer contacts the enrollee, who states that they were directed by a "body broker" working with a substance use disorder treatment facility to submit an application for Marketplace coverage using a false address in a state they did not reside in at the time they enrolled. The issuer has demonstrated that the enrollee intended to provide false information.

Example 12D: An issuer submits a rescission request for a dependent enrollee on a multi-person policy, on the basis that the dependent does not live in their service area. The issuer contacts the subscriber, who states that the dependent enrollee is their child who is attending college out of state but otherwise lives with the subscriber at home (in the state in which the policy was issued). Absent additional information, the issuer has not demonstrated that the subscriber intended to provide false information, since the subscriber considers their dependent child's home address to be their home address.

12.6.3 Material Fact

The issuer must demonstrate that the enrollee (or a person seeking coverage on behalf of the enrollee) made a misrepresentation of a material fact. CMS interprets this provision to mean that the enrollee must have provided information that enabled the individual to enroll in a plan for which they were not eligible. The following are examples of information that could be considered material facts.

- **Residency address**: State of residency address is material because consumers are only eligible to enroll in a QHP in the state in which they reside or intend to reside. However, the details of residency address within a state are not material, because they do not impact eligibility to enroll in a QHP. Therefore, an individual who intentionally mispresents their address within the state they are already enrolled in coverage would likely not be eligible for a rescission, because their intentional misrepresentation would not be of a material fact.
- **Carceral status**: Carceral status is material because consumers who are incarcerated (other than pending disposition of charges) are ineligible to enroll in a QHP.
- **Death**: Death status is material because deceased consumers cannot be enrolled in a QHP.

Note on Misrepresentation of Material Fact: CMS has observed an increase in requests for rescission based on an enrollee's dual enrollment in Medicaid or based on an enrollee's alleged misrepresentation of their projected income. Even if the issuer can demonstrate that an enrollee intentionally misrepresented their income or Medicaid enrollment status, such misstatements would not be with respect to a material fact because enrollment in Medicaid and projected income do not impact eligibility to enroll in a QHP. Therefore, CMS would likely deny the request to rescind.

12.6.3.1 Examples

Example 12E: An issuer submits a rescission request for an enrollee receiving fully subsidized coverage who the issuer has knowledge was enrolled in Medicaid at the time of enrollment in Marketplace coverage. The issuer contacts the enrollee, who states that they indicated on their Marketplace application that they did not have Medicaid because they wanted two forms of coverage. No other information is provided in the rescission request. Although the issuer has demonstrated that the enrollee provided false information (by indicating they were not enrolled in Medicaid at the time they applied for Marketplace coverage) and that they provided such false information intentionally (with the goal of obtaining additional coverage), the issuer has not demonstrated that the intentionally false information provided by the enrollee relates to a material fact because the enrollee's Medicaid enrollment status does not impact their eligibility to enroll in coverage. As a result, CMS will likely deny the request to rescind coverage.[102]

Example 12F: An issuer submits a rescission request for an enrollee on the basis that the enrollee was incarcerated (not pending disposition of charges) at the time of application and provides documentation to demonstrate this. The issuer attempts to contact the enrollee, who does not respond. Because individuals who are incarcerated (other than pending disposition of charges) are not eligible to enroll in Marketplace coverage, the issuer has demonstrated that the enrollee misrepresented a material fact.

[102] However, the enrollee will likely be required to repay any excess APTC received when they file their taxes.

12.7 Distinguishing Between Issuer-Reported UEs and Rescissions

Issuers have asked CMS to provide guidance on how to distinguish between an enrollment that may be rescinded and a UE that may be cancelled. Although these share some characteristics and have a common outcome (cancellation of coverage),[103] UEs and rescissions can be distinguished by whether the enrollee was aware of their enrollment in the policy. An enrollment can be rescinded if an individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact.[104] There is no requirement that an enrollee not be aware of the enrollment, and the enrollee themselves may have committed the fraud, or made an intentional misrepresentation of material fact, giving rise to the enrollment. In contrast, an enrollment may be cancelled as a UE if the enrollee was enrolled in a QHP without his or her knowledge or consent by a third party.[105] Therefore, for a policy to be cancelled as a UE, the enrollee must have been completely unaware of their enrollment in Marketplace coverage.

To determine whether an enrollment can be rescinded (due to fraud or a misrepresentation of a material fact) or cancelled (as a UE), issuers can look at whether there is evidence of activity on the policy. Payment of premiums by the enrollee or contact with the issuer from the enrollee (other than to report a UE) will generally indicate that an enrollment was not a UE, though it may still meet the criteria for a rescission. Although filing of claims is possible with both UEs and rescissions, particular patterns of claim filing, such as immediate out-of-state enrollment in a substance use disorder facility and the filing of high-dollar amounts of claims, will more likely indicate the need for rescission.

[103] Though the AMRC used for each will be different. See the definition of rescission in this document indicating that it is a type of cancellation.
[104] 45 CFR 155.430(b)(2)(iii) and 45 CFR 147.128(a).
[105] 45 CFR 155.430(b)(1)(iv)(C).

13. Implementation of Eligibility Appeal Decisions and Related Enrollments in the FFE

13.1 Background

Under 45 CFR Part 155, Subpart F, individuals have the right to appeal Federally-facilitated Exchange (FFE) eligibility determinations, including but not limited to:

- Eligibility for advance payments of the premium tax credit (APTC), cost-sharing reduction (CSR), and enrollment in a Qualified Health Plan (QHP) through the Exchange.
- Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) where a state has delegated to the FFE the authority to make determinations of eligibility for Medicaid and, if applicable, CHIP, and delegated authority to the Department of Health & Human Services (HHS) appeals entity to adjudicate appeals of any denial of Medicaid or CHIP eligibility pursuant to 42 CFR 431.10 and 42 CFR 457.1120.
- Eligibility for an enrollment period, including Special Enrollment Periods (SEPs) and plan category limitations (PCL).
- Eligibility for enrollment in a catastrophic plan.
- Failure by the Exchange to provide timely notice of an eligibility determination.
- Eligibility for an exemption from the individual responsibility requirement.

The FFE provides written notification to applicants and enrollees advising them of their right to appeal when they receive an eligibility determination, including an explanation that an appeal must be requested within 90 days of the date of the notice of the FFE's eligibility determination.[106] In addition, when applicants and enrollees appeal eligibility redeterminations made by the FFE, they have the right, pursuant to 45 CFR 155.525, to request eligibility pending appeal.

In adjudicating an appeal, the appeals entity for the FFE (the HHS appeals entity) reviews the case anew, considering all the information initially used to determine the individual's eligibility, as well as all relevant facts and evidence gathered through the appeals process, and establishes whether the contested eligibility determination was correct at the time it was made. Marketplace Administrator Review may also take place following the issuance of an appeal decision by the HHS appeals entity to establish whether the contested eligibility determination was correct at the time it was issued. If, on appeal or following Marketplace Administrator Review, the eligibility determination is found to be incorrect, the individual has the option under 45 CFR 155.545(c) to have the Exchange implement the appeal decision prospectively, on the first day of the month following the date of the appeal decision notice or, retroactively with an effective date the individual would have received based on the date the original, incorrect eligibility determination was made, consistent with 45 CFR 155.330(f)(2), (3), (4), or (5), as applicable. In addition, the individual may be granted a 60-day SEP under 45 CFR 155.420, to preserve the enrollment opportunities that the individual would have had, if the eligibility determination had been correct at the time it was made. This SEP begins on the date of the appeal decision and may permit the individual either to enroll in a QHP/Qualified Dental Plan (QDP), or switch QHPs/QDPs, including, at the individual's option, on a retroactive basis.

[106] Sample Eligibility Determination Notices (EDNs), which include information about the eligibility appeal process, are available at https://marketplace.cms.gov/applications-and-forms/notices.html.

13.2 CMS Role

13.2.1 Notify Issuer to Implement an Appeal Decision

When the contested eligibility determination is found to be incorrect and the appeal decision results in a new eligibility determination, an individual can choose to have the appeal decision implemented prospectively or retroactively. The issuer will receive an 834 transaction from the Exchange that communicates the individual's eligibility from the appeal decision, including enrollment effective dates and APTC/CSR eligibility. If an 834 transaction cannot be generated, the issuer will receive a Health Insurance Casework System (HICS) case from the HHS appeals entity. The issuer will receive both an 834 transaction and a HICS case when the APTC/CSR eligibility in the 834 transaction needs to be adjusted. All HICS cases will have the subcategory "Eligibility Appeals Related (OHI Use Only)." Refer to the scenarios that follow for additional information.

If the contested eligibility determination is found to be correct and the appeal decision upholds the Exchange's eligibility determination, the issuer will not receive any communication from the Exchange unless the individual requested eligibility pending appeal. Refer to **Section 13.2.2**, **Notify Issuer to Implement a Request for Eligibility Pending Appeal**, for more information.

13.2.2 Notify Issuer to Implement a Request for Eligibility Pending Appeal

The HHS appeals entity will create a HICS case to notify the issuer when an individual elects to keep their level of eligibility prior to the contested eligibility determination while the appeal is pending. The HICS case will include instructions to the issuer about the level of eligibility to maintain for the particular individual or individuals. All such cases will be recorded in Category 2 (Plan and Issuer Concerns) and the Eligibility Appeals Related (OHI Use Only) subcategory. The case narrative field in the HICS case will begin with "[Consumer name(s)] was granted pended eligibility during their appeal. The issuer is to update its internal systems to reflect the eligibility and date(s) listed below. Once updates are completed, the issuer is to confirm these actions in the HICS Case "Resolution" tab. The issuer should also use Enrollment Data Alignment (EDA) to have the pended eligibility and/or appeal eligibility outlined in this HICS case reflected in the FFE enrollment record."

In certain cases, individuals who requested eligibility pending appeal may only require a continuation of eligibility for a segment of time, because, after a reduction in or loss of APTC/CSR[107] eligibility, they were able to reinstate their eligibility. For example, an individual received APTC/CSR in the prior year and loses their APTC/CSR eligibility effective January 1; then the individual updates their application on January 15 and receives APTC/CSR eligibility effective February 1. Such an individual may request eligibility pending appeal for the month of January only. When this situation occurs, the HICS case for eligibility pending appeal will include a start date and an end date so the individual's subsequent application update (which was effective February 1) is not superseded.

13.2.3 Notify Issuer to Discontinue Eligibility Pending Appeal and Implement the Appeal Decision

At the end of the appeal, which results in either dismissal or an appeal decision, the issuer will receive instructions via a HICS case to discontinue eligibility pending appeal.[108] These instructions will

[107] CSRs cannot be disputed.

[108] The exceptions are if the individual did not request eligibility pending appeal and the appeal is dismissed, or the HICS case instructing the issuer to implement eligibility pending appeal includes an end date.

include the effective date to end the eligibility that the individual received while the appeal was pending, and, if applicable, the coverage effective date to apply the eligibility awarded in the appeal decision. The HICS case will include the HICS case ID number for the previous HICS case that communicated the instructions for eligibility pending appeal. The Case Narrative field in the HICS case will begin with "[Consumer name(s)]'s appeal concluded. The issuer is to update its internal systems to reflect the eligibility/enrollment and date(s) listed in the action below. Once updates are completed, the issuer is to confirm these actions in the HICS case Resolution tab. The issuer should also use EDA to have the pended eligibility and/or appeal eligibility outlined in this HICS case reflected in the FFE enrollment record." The issuer is to update its internal systems to reflect changes to the enrollment and to any APTC/CSR eligibility, as applicable.

Sometimes, an enrollee may independently update their enrollment during the pendency of the appeal. Should that occur, the HICS case containing instructions to discontinue eligibility pending appeal will include further language instructing the issuer to stop eligibility pending appeal the day before the independent enrollment and leave the subsequent, established enrollment unchanged. The HICS case will include the following additional language "The enrollment record reflects that the consumer updated their eligibility and enrollment. The consumer's eligibility and enrollment from the independent update was transmitted to the issuer via 834 and should continue unchanged."

In limited circumstances, an individual receiving eligibility pending appeal may be permitted to revert to a lower level of coverage if the appeal decision upholds the contested eligibility determination. For example, an individual was eligible for APTC/CSR in the prior-year, but their eligibility was redetermined and they were found ineligible for APTC/CSR during the Open Enrollment Period (OEP). The individual enrolls in a Bronze plan because they are ineligible for CSR. They appeal the redetermination and request eligibility pending appeal. They are granted eligibility pending appeal and enroll in a Silver plan with APTC/CSR. Their appeal decision upholds the Exchange's eligibility determination. They are eligible for an SEP under 45 CFR 155.420(d)(6)(i) and permitted to enroll in any plan.

13.3 Issuer Role

13.3.1 Enrollment Requirements

Issuers play a critical role in implementing an individual's appeal decision and, if applicable, the individual's request for eligibility pending appeal.

- Once an individual is determined eligible for an SEP as a result of the appeal decision, an issuer is responsible for enrolling any individual who selects a plan offered by that issuer through the Exchange and applying any APTC/CSR for which the individual is found eligible upon appeal, as instructed by the FFE.
- Where the individual is found eligible for and chose a retroactive effective date based on the appeal decision, the issuer is responsible for processing or re-processing the individual's claims incurred during the period of retroactive coverage, collecting premiums from the individual for months of retroactive coverage, and providing the applicable period of time to make payment consistent with **Section 6**, **Premiums (Applicable to the Individual Market FFE, QHPs/QDPs)**.
- In the case of retroactive changes to eligibility for APTC/CSR, the issuer is responsible for refunding or crediting any excess cost-sharing or premiums paid to the enrollee consistent with

Section 6, **Premiums (Applicable to the Individual Market FFE, QHPs/QDPs)**, and applicable state law.

- In the case of an individual's request for eligibility pending appeal, upon notification from the HHS appeals entity, the issuer must maintain the individual's enrollment and APTC and, if applicable, CSR eligibility level that were in effect prior to the redetermination being appealed. Similarly, at the conclusion of the appeal, upon notification from the HHS appeals entity, the issuer must implement the individual's corrected eligibility specified in the appeal decision and, if applicable, discontinue eligibility pending appeal.
- In the case of retroactive changes, the issuer may need to submit the correction to the Enrollment Resolution and Reconciliation (ER&R) contractor in order to ensure the FFE is updated and proper payment from CMS.

13.3.2 HICS Case Resolution Requirements

Upon receipt of a HICS case instructing an issuer to update its enrollment records based on an appeal decision or eligibility pending appeal, the issuer must complete the following actions:

- Update its enrollment records.
- Contact the individual to provide the resolution in accordance with the directions in the HICS narrative.
- Close the HICS case with resolution notes acknowledging that its records have been updated and that it contacted the individual to provide the resolution in accordance with the HICS case narrative directions.
- Meet the timeliness and notification requirements outlined in 45 CFR 156.1010(d) for all appeals-related HICS cases, whereby an issuer must take action to implement the directions in the HICS case narrative for an appeal-related case no later than 15 days after receipt of the HICS case, and, in cases of expedited appeals (which will be coded as expedited cases in HICS), within 72 hours after receipt of the HICS case.
- Use EDA processes,[109] including the ER&R dispute process (which includes HICS Direct Disputes), to ensure that the FFE policy record reflects the APTC and CSR amounts granted to the individual and implemented by the issuer pursuant to eligibility pending appeal and, as applicable, the appeal decision that was communicated via HICS. This is necessary for the accuracy of the taxpayer's Form 1095-A as well as issuer policy-based payment (PBP).
    - If the update requires a retroactive adjustment or adjustment to financials, the issuer must update their next Reconciliation Inbound (RCNI) file and submit the HICS case to the ER&R contractor using the HICS Direct Dispute process to ensure the FFE policy is updated correctly.

Issuers must follow regulatory guidelines for communication with individuals and are encouraged to adopt the HICS case best practices. Recommended language to include in the issuer resolution notes is as follows:

"We updated our internal systems on [date of the update] to reflect changes to [Consumer Name]'s enrollment and to any APTC/CSR eligibility."

[109] The EDA process is the process that FFE uses to ensure the accuracy and completeness of the information transmitted and to maintain consistent information between issuers and the FFE. More information about this process is available in **Section 9**, **Enrollment Data Alignment (Applicable to Individual Market FFE, QHPs/QDPs)**.

Include the following, as applicable to the case:

- Enrollment effective date: [effective date].
- Monthly amount of APTC and effective date: [APTC amount and effective date].
- CSR level and effective date: [CSR level and effective date].
- Enrollment termination date: [effective date of disenrollment].
- Monthly amount of APTC and end date: [APTC amount and end date].
- CSR level and end date: [CSR level and end date].

13.4 Appeal Decision Scenarios

Exhibit 32: Appeal Decision Scenarios

Appeals Outcome	Enrollment Actions
Scenario #1. The individual is not enrolled in a QHP. The individual receives an appeal decision finding that the contested determination of ineligibility for APTC/CSR is incorrect, and the individual is eligible for APTC/CSR. The individual opts to have the decision implemented **prospectively**.	• The issuer receives an 834 enrollment transaction and/or HICS case with the individual's plan selection, APTC/CSR eligibility, and prospective effective date. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the EDA process. More information about this process is available in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.
Scenario #2. The individual is not enrolled in a QHP. The individual receives an appeal decision finding that the contested determination of ineligibility for APTC/CSR is incorrect, and the individual is eligible for APTC/CSR. The individual opts to have the decision implemented **retroactively**.	• The issuer receives an 834 enrollment transaction and/or HICS case with the individual's plan selection, APTC/CSR eligibility, and retroactive effective date. • The issuer processes the individual's enrollment, collects payment necessary to effectuate coverage retroactively, and processes claims submitted by the enrollee or the enrollee's care providers for services furnished on or after the retroactive enrollment effective date. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the EDA process. More information about this process is available in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.
Scenario #3. The individual was enrolled in a QHP with APTC/CSR, but their coverage was terminated due to non-payment because they lost APTC/CSR eligibility and did not make full payments. The individual receives an	• The issuer receives an 834 enrollment transaction and/or HICS case with the individual's plan selection, APTC/CSR eligibility, and retroactive effective date. • The issuer collects premiums in accordance with 45 CFR 155.400(e), and re-enrolls the individual, refunds or credits to the enrollee any excess premiums paid,

Appeals Outcome	Enrollment Actions
appeal decision finding that the contested determination of ineligibility for APTC/CSR is incorrect, and the individual is eligible for APTC/CSR. The individual opts to have the decision implemented **retroactively**, and where the individual wants to re-enroll in the same coverage that was terminated, the prior termination for non-payment is considered erroneous and the issuer is directed to **reinstate enrollment into the prior plan**.	reprocesses claims to account for the application of the higher level of CSR (if applicable), and refunds to the enrollee any excess cost-sharing paid in accordance with applicable state law. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the EDA process. More information about this process is available in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.
Scenario #4. The individual is enrolled in a QHP with APTC/CSR. The individual receives an appeal decision finding that the contested determination of the amount of APTC/CSR for which the individual is eligible is incorrect, and that the individual should have been determined eligible for a different amount of APTC/CSR. The individual opts to have the decision applied **retroactively** in the same QHP.	• The issuer receives an 834 enrollment transaction and/or HICS case with the enrollee's plan selection, APTC/CSR eligibility, and retroactive effective date. • The issuer processes the adjustments to the enrollee's enrollment, refunds or credits to the enrollee any excess premiums paid, reprocesses claims to account for the application of the higher level of CSR (if applicable), and refunds to the enrollee any excess cost-sharing paid in accordance with applicable state law. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the EDA process. More information about this process is available in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.
Scenario #5. The individual is enrolled in a QHP without APTC/CSR. The individual receives an appeal decision finding that the contested determination of ineligibility for APTC/CSR is incorrect, and that the individual should have been determined eligible for APTC/CSR. The individual opts to enroll retroactively in a **different** QHP offered by the **same** issuer.	• The issuer receives an 834 enrollment transaction and/or HICS case for the **gaining** QHP with the enrollee's plan selection, APTC/CSR eligibility, and retroactive effective date. • The issuer receives an 834 termination transaction or HICS case for the **former** QHP with a 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 CSR level under the **gaining** QHP. This should be done as if the claims had initially been submitted to the **gaining** QHP. CMS also encourages the issuer to apply any out-of-pocket costs incurred under the **former** QHP toward the **gaining** QHP deductible and maximum out-of-pocket costs to the extent such incurred amounts exceed out-of-pocket

Appeals Outcome	Enrollment Actions
	costs that would have been incurred under 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, in accordance with applicable state law. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the EDA process. More information about this process is available in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.
Scenario #6. The individual is enrolled in a QHP without APTC/CSR. The individual receives an appeal decision finding that the contested determination of ineligibility for APTC/CSR is incorrect, and that the individual should have been determined eligible for APTC/CSR. The individual opts to enroll retroactively in a **different** QHP offered by a **different** issuer.	• The **gaining** issuer receives an 834 enrollment transaction and/or HICS case with the individual's plan selection, APTC/CSR eligibility, and retroactive effective date for the **gaining** QHP. • The **former** issuer receives an 834 termination transaction or HICS case with a retroactive termination effective date for the **former** QHP. • The **former** issuer terminates the enrollee's coverage, refunds premiums, and reverses claims payments, in accordance with applicable state law. • The **gaining** issuer collects premiums for all months of coverage in accordance with 45 CFR 155.400(e), effectuates coverage, and processes claims submitted by the enrollee, or the care providers, for services furnished on or after the retroactive enrollment effective date, accounting for the application of APTC/CSR. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the EDA process. More information about this process is available in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.
Scenario #7. The individual is enrolled in a QHP without APTC/CSR. The individual receives an appeal decision finding that the contested determination of ineligibility for APTC/CSR is incorrect, and that the individual should have been determined eligible for APTC/CSR. The individual opts to have	• The issuer receives an 834 enrollment transaction and/or HICS case for the **gaining** QHP with the individual's plan selection, APTC/CSR eligibility, and effective date. • The issuer receives an 834 termination transaction or HICS case for the **former** QHP with a termination effective date.

Appeals Outcome	Enrollment Actions
the adjusted APTC/CSR amounts applied retroactively to the current QHP, and to enroll prospectively in a **different** QHP offered by the **same** issuer.	• If necessary, the issuer receives a HICS case adjusting APTC/CSR for the **former** QHP because the enrollee opted to have the corrected APTC/CSR amounts applied retroactively to the **former** QHP. • The **former** QHP refunds or credits to the enrollee any excess premiums paid, accounting for the application of APTC, reprocesses claims with the enrollee's corrected CSR level, and refunds to the enrollee any excess cost-sharing paid, in accordance with applicable state law. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the EDA process. More information about this process is available in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.
Scenario #8. The individual is enrolled in a QHP with APTC/CSR. The individual receives an appeal decision finding that the contested determination of the amount of APTC/CSR for which the individual is eligible is incorrect, and that the individual should have been determined eligible for a different amount/level of APTC/CSR. The individual opts to have the revised APTC/CSR amounts applied retroactively to the current QHP, and to enroll prospectively in a **different** QHP offered by a **different** issuer.	• The **gaining** issuer receives an 834 enrollment transaction and/or HICS case with the individual's plan selection, APTC/CSR eligibility, and effective date for the **gaining** QHP. • The **former** issuer receives an 834 termination transaction or HICS case with a termination effective date for the **former** QHP. • If necessary, the issuer receives a HICS case adjusting APTC/CSR for the **former** QHP because the enrollee opted to have the corrected APTC/CSR amounts applied retroactively to the **former** QHP. • The **former** issuer terminates the enrollee's enrollment, refunds premiums, and reverses claims payments, in accordance with applicable state law. • The **gaining** issuer collects premiums for all months of coverage in accordance with 45 CFR 155.400(e), effectuates 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, accounting for the application of APTC/CSR. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the EDA process. More information about this process is available in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.

Appeals Outcome	Enrollment Actions
Scenario #9. The individual is enrolled in a QHP with APTC/CSR. The individual receives an appeal decision finding that the contested determination of eligibility for APTC/CSR is incorrect, and that the individual should not have been determined eligible for enrollment into a QHP with APTC/CSR. The individual opts to terminate their QHP coverage retroactively.	• The issuer receives a HICS case with a retroactive termination effective date. • Upon receiving the HICS case, the issuer terminates the enrollee's QHP coverage. • The issuer reverses claims payments and refunds any premiums and cost-sharing paid by the enrollee in accordance with applicable state law. • The issuer must submit these enrollment changes via the EDA process. More information about this process is available in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.
Scenario #10. The individual is enrolled in a QHP with APTC/CSR. The individual reports a life change (ESC-MEC [minimum essential coverage] eligibility that does not offer family coverage) and all application members' QHP enrollment is terminated. The individual is contesting that the individual's termination date is incorrect and that the remaining members on the application should remain covered. The individual receives an appeal decision finding that the contested eligibility determination was incorrect. The individual opts to reinstate coverage for all members on the application except for themselves and retroactively terminate their QHP on the date initially requested.	• The issuer receives an 834 enrollment transaction and/or HICS case (for all members) with the enrollee's plan selection, APTC/CSR eligibility, and retroactive effective date. • The issuer receives an 834 enrollment transaction or HICS case that terminates the member gaining ESC-MEC while updating enrollment for the remaining members with the plan selection, APTC/CSR eligibility, and effective date. • The issuer processes the adjustments to the enrollee's enrollment, refunds or credits to the enrollee any excess premiums paid, reprocesses claims to account for the application of the higher level of CSR, and refunds to the enrollee any excess cost-sharing paid in accordance with applicable state law. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the EDA process. More information about this process is available in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.
Scenario #11. The individual is enrolled in a QHP with APTC/CSR. The individual reports a life change and is found ineligible for APTC/CSR. The individual is contesting the redetermination that they are not eligible for APTC/CSR and chooses to continue receiving APTC/CSR during their appeal. Then, the individual receives an appeal decision finding that the contested eligibility determination was correct upholding the Exchange's eligibility	• The issuer receives a HICS case for eligibility pending appeal with the effective date and APTC/CSR eligibility. The issuer must apply this eligibility while the appeal is pending. • The issuer processes the APTC/CSR eligibility and effective date to the enrollee's enrollment, refunds or credits to the enrollee any excess premiums paid, reprocesses claims to account for the application of CSR, and refunds to the enrollee any excess cost-sharing paid in accordance with applicable state law. • The issuer must submit these enrollment changes via the EDA process. More information about this process

Appeals Outcome	Enrollment Actions
determination.	is available in **Section 9.4.8**, **HICS Direct Dispute Process**. • Once the appeal is decided, the issuer receives a HICS case with an effective date that ceases the provision of APTC/CSR. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the EDA process. More information about this process is available in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.
Scenario #12. The individual is enrolled in a QHP with APTC/CSR. The individual reports a life change and is found ineligible for APTC/CSR. The individual is contesting the redetermination that they are not eligible for APTC/CSR and chooses to continue receiving APTC/CSR during their appeal. Then, the individual receives an appeal decision finding that the contested eligibility determination was incorrect, overturning the Exchange's eligibility determination.	• The issuer receives a HICS case for eligibility pending appeal with the effective date and APTC/CSR eligibility. The issuer must apply this eligibility while the appeal is pending. • The issuer processes the APTC/CSR eligibility pending appeal and effective date to the enrollee's enrollment, refunds or credits to the enrollee any excess premiums paid, reprocesses claims to account for the application of CSR, and refunds to the enrollee any excess cost-sharing paid in accordance with applicable state law. • The issuer must submit these enrollment changes via the EDA process. More information about this process is available in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**. Once the appeal is decided, the issuer receives a HICS case with an effective date that ceases the provision of APTC/CSR eligibility pending appeal. • Once the appeal is decided, the issuer receives an 834 enrollment transaction and/or HICS case with the enrollee's plan selection, APTC/CSR eligibility, and effective date. • The issuer must apply the eligibility submitted by the HHS appeal entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the EDA process. More information about this process is available in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.
Scenario #13. The individual is enrolled in a QHP with APTC/CSR. The individual attempts to add a dependent (e.g., birth, adoption) to their application	• The issuer receives an 834 enrollment transaction and/or HICS case (including the dependent) with the enrollee's plan selection, APTC/CSR eligibility, and effective date.

Appeals Outcome	Enrollment Actions
but is unsuccessful due to an Exchange technical error. The individual receives an appeal decision awarding an SEP to enroll the dependent. The individual opts to enroll the dependent retroactively in the current plan.	• The issuer processes the adjustments to the enrollee's enrollment, 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. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the EDA process. More information about this process is available in **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**.

13.5 Impact of Appeals on Enrollment Data Reconciliation

The HHS appeals entity communicates appeal decisions that yield policy level updates to issuers via HICS. Enrollment changes due to appeal decisions implemented before March of the subsequent year should be updated utilizing the Inbound 834 (IC834) process where possible. This includes effectuating, cancelling, or terminating policies. The IC834 process can also reinstate most policies or coverage spans.

If the IC834 process cannot resolve the HICS case, the issuer should submit the updates on the next RCNI. If the update requires a retroactive adjustment or adjustment to financials, the issuer must submit the HICS case to the ER&R contractor using the HICS Direct Dispute process in addition to the RCNI update to ensure the FFE policy is updated correctly. Refer to **Section 9**, **Enrollment Data Alignment (Applicable to Individual Market FFE, QHPs/QDPs)**, for additional guidance on submitting updates through the monthly Enrollment Data Reconciliation process.

There are some situations where current-year appeals must be submitted to the ER&R contractor through the dispute process because the monthly Enrollment Data Reconciliation process is unable to update the FFE. Refer to **Section 9**, **Enrollment Data Alignment (Applicable to Individual Market FFE, QHPs/QDPs)**, for guidance on how to submit disputes to update the FFE's records.

Enrollment changes due to appeal decisions implemented after March of the subsequent year (once Enrollment Data Reconciliation and IC834 transactions have concluded for prior-year coverage) must be submitted via the ER&R Enrollment Dispute process (see **Section 9.4**, **Resolution of Enrollment and Payment Discrepancies (Disputes)**). These updates will also be noted on the next Pre-Audit File released for the year that the update was made in the FFE. Refer to the *Pre-Audit and Reconciliation Calendar* for delivery dates of each Pre-Audit File. It can be located at https://zone.cms.gov/document/enrollment-data-reconciliation.

14. HEALTH INSURANCE CASEWORK SYSTEM

14.1 Introduction

The Health Insurance Casework System (HICS) is the official tracking system for Exchange casework and is used by issuers that participate in the Federally-facilitated Exchange (FFE) and State-based Exchanges on the Federal Platform (SBE-FPs). The HICS system is the means by which the Marketplace Call Center routes cases to issuers that require investigation and resolution.

HICS is also used to direct an issuer to make changes to enrollment effective and end dates, changes to advance payments of the premium tax credit (APTC) and cost-sharing reduction (CSR) resulting from appeal decisions and other corrections, when the change via 834 transactions or Pre-Audit Files is not possible.

CMS Caseworkers and Account Managers provide technical assistance through the HICS case to issuers or other CMS staff when needed. In addition, the Office of Hearings and Inquiries (OHI) and Eligibility Appeals Support Contractors (EASC) utilize HICS to communicate appeals decisions to issuers.

14.2 HICS Access

HICS is accessible to approved users via https://idm.cms.gov/. Users are required to comply with all applicable laws and regulations associated with the use of this U.S. Government computer system. Issuers that need HICS access will now be required to complete and submit applications through IDM. The system enhancements offer new electronic receipt and processing of applications for HICS access that eliminates the burden of completing and retaining paper records and physically moving paper applications through multiple steps of the HICS application process. Issuers should download the updated guidance on how to access HICS from the Qualified Health Plan (QHP) Published Guidance & Regulations page website (information found on the bottom of the page). After logging on to the system, users can access the Issuer User Manual by selecting ***Documentation*** on the Casework Tracking Start Page menu.

Staff requesting HICS access from an issuer should select the ***Issuer*** role in IDM. Currently this is the only role for issuer HICS access. For additional questions about HICS access, issuers can contact the HICS Access Resource Mailbox at HICS_Access@cms.hhs.gov. HICS users must comply with the annual recertification requirement when notified and complete annual Computer Based Training.

Issuers are expected to acquire and maintain sufficient access to HICS for their staff and train them to use the system. Having sufficient staff access to HICS will aid with issuer responsiveness, potentially avoiding the generation of additional and unnecessary HICS cases. Because HICS contains personally identifiable information and personal health information, issuer compliance with all applicable CMS privacy and security certification and training is required.

14.3 HICS Category Use

For simplicity and administrative ease, issues in HICS are grouped into one of five categories. Every case recorded in HICS must be assigned a category and subcategory. Category 2, designated as Plan and Issuer Concerns, has been established to record cases related to access to benefits, premiums, and

services provided by a QHP only. The term "QHP" includes Consumer Operated and Oriented Plans (CO-OPs), Qualified Dental Plans (QDPs), and Multi-State Plans (MSPs).

Marketplace Call Center cases are concurrently assigned to an issuer and the CMS Lead Caseworker associated with that issuer in the daily casework load. Category 2 cases where QHPs are not identified are placed in an unassigned grouping for CMS review based on the consumer's state.

Per 45 CFR 156.1010, resolution and consumer notification all have separate regulatory timeliness requirements. Issuers are to resolve Level 1 (urgent) cases within 72 hours of receiving the case and Level 2 (non-urgent) cases within 15 calendar days of receiving the case. Issuers must notify complainants regarding the disposition of the case as soon as possible upon resolution of the case but in no event later than three business days after the case is resolved. Notification may initially be performed verbally, but all cases must be responded to in writing. The verbal notification of the resolution of the cases will satisfy the timely notification requirement. In instances when the initial notification of a case's disposition was verbal, written notification must be provided to the consumer in a timely manner. A resolution summary of the case must be documented in HICS no later than seven business days after resolution of the case. The record must include a clear and concise narrative explaining how the case was resolved, including information about how and when the complainant was notified of the resolution and what Enrollment Data Alignment (EDA) method was used to align issuer records with the FFE.

Issuers have the ability to view and search Category 2 cases if the case is assigned to them unless the case is marked as a "CMS Issue." Only issuers with access for that issuer Health Insurance Oversight System (HIOS) ID can see their member's cases. For example, Company A is not able to see cases from Company B's customers.

14.4 HICS Casework and Expectations

CMS expects QHP and QDP issuers to thoroughly investigate and resolve individual issues received directly from members or reach out to their CMS Lead Caseworker or Account Manager for assistance or additional guidance. Additionally, issuers operating in the Exchange must investigate and resolve individual cases, including complaints, forwarded by CMS via HICS in accordance with the requirements at 45 CFR 156.1010. Issuers should check HICS daily and monitor adherence to required resolution time frames. To avoid delays, issuer staff should have appropriate access to enrollment files without the need for escalation to other internal issuer departments. If a case narrative is unclear, the issuer is expected to contact the individual for additional information prior to referring the case back to CMS.

CMS routinely monitors issuer compliance with casework handle times described in 45 CFR 156.1010. CMS measures the handle time of HICS cases based on the issuer assignment date/timestamp and resolution date/timestamp. The handle time calculation is performed down to the minute for both issue level 1 and 2 cases. Issuers who fail to resolve HICS cases (issue level 1 or 2) timely 95 percent of the time may be subject to progressive compliance actions. This includes but is not limited to technical assistance, corrective action plan, and notice of non-compliance.

Exhibit 33 identifies the expected issuer resolution time for each issue level and the case type.

Exhibit 33: Issuer HICS Resolution Times

Type of Case	Issuer HICS Resolution Time	Notes
Level 1	Within 72 hours of the issuer assignment date*	Resolution summary of the case added no later than seven days after resolution
Level 2	Within 15 calendar days of the issuer assignment date	Resolution summary of the case added no later than seven days after resolution
Plan Request	-	The issuer assignment date will update if the plan request is accepted by the CMS Caseworker and subsequently returned to the issuer. If the plan request is rejected, the issuer assignment date will remain the same.

***NOTE**: Turnaround times are driven by the Assignment Date field in HICS, which correlates to when the case is assigned to the issuer.

When reviewing HICS cases, issuers should distinguish between directive cases that require them to act and non-directive individual requests that require review prior to action and/or resolution. For example, an appeal decision sent via HICS from "Case Source: CMS Appeals Contractor" will include a case narrative (see case narrative guidance) and changes that the issuer must effectuate as directed. The issuer must update the Exchange through the EDA process (see **Section 9**, **Enrollment Data Alignment (Applicable to Individual Market FFE, QHPs/QDPs)**). Similarly, if an issuer receives a Special Enrollment Period (SEP) enrollment with an EX code and a corresponding HICS case stating that a specific retroactive coverage effective date should be applied, the issuer should treat that as a CMS directive. In contrast, a case narrative such as "Individual believes that they were terminated in error and desires reinstatement," is a non-directive narrative that requires the issuer to investigate first. The issuer should take action to update the individual's record in accordance with applicable laws and policies and only if supported by evidence the individual provides or the issuer develops. In all cases, the issuer must contact the individual with the resolution of the HICS case.

Infrequently, a HICS case narrative may include directive instructions from CMS that the issuer believes to be inconsistent with law or policy. In this situation, the issuer should work with CMS to resolve the matter, starting with the assigned CMS Caseworker and/or Account Manager. Issuers should not effectuate requests inconsistent with CMS policy and guidance.

In general, issuers are not able to reassign HICS cases. With a recent implementation of the HICS Plan Request functionality, specific cases may now be routed directly to a CMS Caseworker for review, technical assistance, and reassignment to a different issuer; the Enrollment Resolution and Reconciliation (ER&R) contractor to work for Direct Disputes; and the Office of Hearings and Inquiries (OHI) and Eligibility Appeals Support Contractors (EASC) for appeals clarification. These plan requests may include (but are not limited to) cases that require CMS approval for retroactivity or eligibility determination, enrollment blockers (new error code "enrollment blocker"), changes to APTC, changes to total premium amount that cannot be resolved through automated Enrollment Data Reconciliation, and term no longer eligible (NLE) appeals.

If the plan request is accepted, the case will generally be removed from the issuer's view, and the case will no longer be subject to issuer timeliness requirements. If the case is returned to the issuer after review, the issuer assignment date will reset. This should prevent cases reassigned to issuers from being counted as untimely. However, issuers are expected to resolve the case within the allotted time allowed per 45 CFR 156.1010. The time the ER&R contractor is allowed to resolve a HICS Direct Dispute will be similar to disputes submitted via an Enrollment Dispute Form and therefore not counted against the issuer's resolution timeline.

Issuers must continue to review and resolve individual issues after leaving a service area. Issuers entirely exiting Exchange operations should contact their Account Manager about continued casework expectations.

14.5 HICS Casework Best Practices

CMS expects issuers to always annotate cases with comprehensive notes. As a best practice, issuers should immediately annotate actions taken in HICS. Notes at each stage should include the following:

Initial Issuer Notes:

- Acknowledge receipt.
- Enter a brief issue description, including clarifying details not present in the CMS case narrative.
- Find related cases and prevent duplicative work by utilizing the Find Repeat Case feature, and record related cases found.

Interim Issuer Notes:

- Clearly and concisely summarize each step taken, especially if approaching timeliness deadline. Include: actions taken; internal referrals; and/or contact with CMS staff.
- Contact Information:
  - Who: Identity verified, names and relationships/titles
  - When: Dates and times
  - How: Method of contact (Including phone numbers and email addresses)
  - What: Summary of the information received and conveyed

Resolution Issuer Notes and Documentation:

- Resolution notes should be more extensive than brief one-liners like: Contact Made, Issue Resolved, and Unable to Contact
- Pertinent case facts, for example:
  - Issuer records updated and/or external referrals to ER&R or the Marketplace Service Desk (MSD)
  - Enrollment or termination information received electronically from CMS
  - Effective date and termination dates, including prior-year effective dates and information as it relates to prior-year eligibility appeals effectuation
  - Payment and billing history
  - Summary of resolution (how the case was resolved)
  - Information about how and when the complainant was notified of the resolution

- How and when Complainant Was Notified of Outcome (Verbal and Written or Written Only)
- Uploaded Copies of Correspondence Sent to Individuals and Other Entities

If the issuer requires assistance, the issuer should contact their CMS Caseworker and/or Account Manager prior to resolving the case. Issuers may choose to establish a critical inquiry unit to resolve difficult cases. In some situations, HICS case notes may be released to requestors under the Freedom of Information Act (FOIA). Therefore, case notes' content and comments should be clear, neutral, and factual.

For additional resources when working HICS cases, CMS has released the following guidance through REGTAP and frequently publish updated or additional guidance:

- Exchange Issuer Best Practices 2019 (November 19, 2018)
- Exchange Issuer Best Practices 2020 (February 10, 2020)
- HICS Enrollment Related Scenarios (January 14, 2019)
- Health Insurance Casework System (HICS) Direct Dispute Enrollment Q&As (July 17, 2017)
- Issuer Refresher on Handling Terminations in the Federally-facilitated Exchange (FFE) (October 31, 2022) and Health Insurance Casework System (HICS) to Change Termination Date (August 5, 2019)
- Non-Special Enrollment Period (SEP) Change in Circumstance (CIC) Grouping Error (February 4, 2019) and Enrollment Blocker Process Update (March 9, 2020)
- Enrollment Blocker Refresher (April 3, 2023)
- Casework Overview and Unauthorized Enrollments Using HICS (April 24, 2019)

15. DATA MATCHING ISSUES MONTHLY PROCESSES

15.1 What Are Data Matching Issues or Inconsistencies?

When individuals apply for coverage through the Exchanges, including through HealthCare.gov, the applicable Exchange verifies information that is provided by the individual on their application. Most applicants' information is immediately verified by the Exchange, however, in some cases, the information the applicant provided does not match up immediately with existing records or the applicant may not have provided enough information to match with the Exchange trusted data sources. These types of situations are called data matching issues/inconsistencies (DMIs).

Examples of DMIs include the following:

- Citizenship
- Immigration status
- Annual Household Income
- Access to or enrollment in employer-sponsored minimum essential coverage (MEC) or health coverage from another public entity
- American Indian/Alaska Native status

15.2 How Does an Enrollee Know if They Have a DMI?

Enrollees are informed of DMIs in their initial Eligibility Determination Notice (EDN). The notice will let them know that they need to verify information on their application. At that time, the 90-day time frame for providing acceptable documentation is started.

NOTE: For citizenship and immigration DMIs, individuals have a 95-day time frame.

Enrollees are also able to view whether they have a DMI in logging into their online Marketplace account under the Eligibility Results page at HealthCare.gov.

Additionally, enrollees receive a series of Warning Notices: (separate 30-day, 60-day and 90-day notices), updating them on how much time they have left to resolve their DMI. Enrollees can read these notices in their online Marketplace account at HealthCare.gov. They also receive a phone call after submitting insufficient documentation and/or after DMI generation if no document is submitted.

NOTE: Enrollees may also receive emails or texts from the Marketplace if an individual selected email or text as their preferred form of communication.

15.3 Exchange DMIs Issuer Outreach Files Delivery Processes and Impact to Enrollees

Enrollees must resolve their DMIs by providing additional information to the Exchange within 90 days (95 days for citizenship or immigration status DMIs). Enrollees with DMIs who are otherwise eligible are able to enroll in coverage through the Exchange during their inconsistency period.

If sufficient documentation is received during the inconsistency period to resolve a DMI, the Exchange finalizes the eligibility determination. If they do not resolve the DMIs, individuals with citizenship or immigration status DMIs may lose eligibility for coverage through the Exchange and enrollees with

other DMIs may undergo a loss or adjustment of their advance payments of the premium tax credit (APTC) and/or cost-sharing reduction (CSR) that could impact their monthly healthcare expenses.

In most situations where one member of an enrollment group is determined not to be a qualified individual (QI), the members of the enrollment group who remain eligible for enrollment through the Exchange would constitute an enrollment group that can be accommodated by the existing Exchange coverage. For example, if two parents and two children are in an enrollment group and one parent loses eligibility for enrollment through the Exchange, the remaining three family members could still constitute a valid enrollment group. If the remaining members of the enrollment group are still eligible for enrollment through the Exchange, and for APTC or CSR, if applicable, they may be able to continue their enrollment through the Exchange, along with their APTC or CSR.

Where the individual who is determined not to be a QI is also the subscriber of the Qualified Health Plan (QHP) and has their coverage terminated, and the remaining members of the enrollment group re-enroll in coverage with the same issuer through the Exchange, 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 QHP, and the QHP allows for removal of that dependent as an amendment to the policy, the issuer must apply any amounts previously paid toward deductibles and out-of-pocket limits toward the continuing coverage of the remaining members of the enrollment group.

In some situations, the removal of one or more members from an enrollment group results 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. If the removal of the individual who was determined ineligible for enrollment through the Exchange results in the remaining eligible members of the enrollment group being unable to continue their enrollment in their same QHP, they will receive a Special Enrollment Period (SEP) to enroll in a QHP through the Exchange.

15.3.1 DMIs Outreach Schedule and Process

During the inconsistency period, issuers are encouraged to conduct outreach to enrollees who have unresolved DMIs. The Exchange will process outreach file transaction data that identifies enrollees with unresolved DMIs. The outreach file represents enrollments for individuals who may experience a change in eligibility for financial assistance or Exchange enrollment unless they successfully resolve their DMI. The Exchange sends the outreach files to issuers via Electronic File Transfer (EFT) code DATAM to give issuers an opportunity to conduct optional outreach to these enrollees. Enrollees who experience an adjustment in eligibility to be enrolled in a QHP or for financial assistance; loss or adjustment of APTC and CSR, due to an unresolved DMI, will be indicated on the 834 transaction files to the issuer. As such, issuers will be able to identify if a policy is being modified by the origin code populated on the M834 transaction.

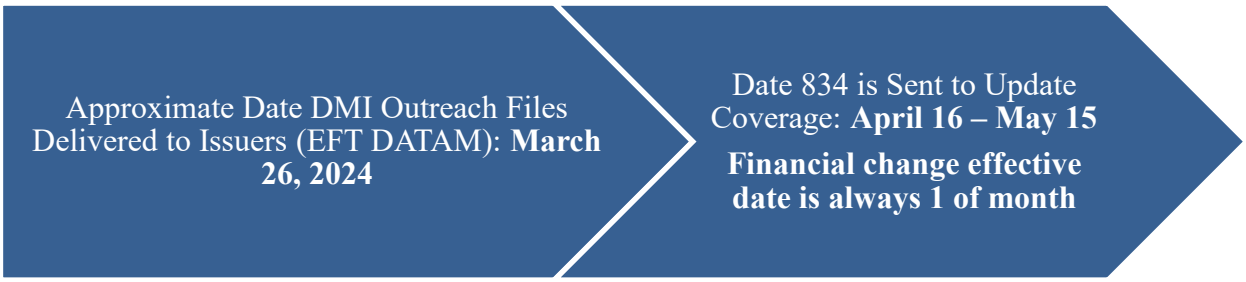
An enrollee who loses eligibility for enrollment through the Exchange due to a DMI will be directed to the issuer to pursue coverage outside the Exchange, if desired by the enrollee. The enrollee will not receive any APTC or CSR for any coverage outside the Exchange, however; the enrollee in these scenarios will generally be eligible for an SEP based on a loss of coverage, if applicable, or change in eligibility for APTC and/or CSR. The issuer is expected to work with the enrollee to avoid gaps in coverage and is encouraged to apply any amounts paid toward deductibles and out-of-pocket limits toward the enrollee's coverage outside the Exchange if such coverage is under a different policy. To

the extent the coverage continues uninterrupted outside the Exchange, any amounts paid toward deductibles and out-of-pocket limits would continue uninterrupted as well.

15.3.2 Exchange DMI File Delivery Schedule

As shown in **Exhibit 34**, DMI Outreach files are delivered to issuers approximately the fourth Tuesday of each month. The related 834 transaction information within the DMI Outreach files identifies consumers with unresolved DMIs approximately 3–7 weeks away from the file date, allowing issuers this window of time to conduct optional consumer outreach.

Exhibit 34: Example Delivery and Transaction Schedule



Issuers are advised not to update their systems with the information contained in the DMI outreach file (sent via EFT DATAM). 834 transactions from the Exchange will be sent to issuers to adjust the coverage of enrollment groups impacted. When the Federally-facilitated Exchange (FFE) cannot resolve a type of DMI that results in an enrollee being determined not eligible for coverage through the Exchange, an 834 termination transaction is sent from the FFE notifying the issuer of the termination of the enrollee's enrollment through the Exchange and termination of eligibility for APTC and CSR, if applicable.

15.4 Late Submission of Documentation for DMIs

Enrollees whose FFE enrollment status and eligibility for APTC and/or CSR, if applicable, are adjusted or terminated due to their failure to submit sufficient data matching documentation, are provided with an opportunity to re-enroll in individual market coverage through the FFE outside of the Open Enrollment Period (OEP) by producing sufficient documentation to resolve the DMI. In accordance with 45 CFR 155.420(d)(13), the FFE provides a 60-day SEP for such an enrollee 1) who submits the requested supporting documentation to the FFE; 2) for whom the verification sources are able to establish information based on the trusted external data sources (EDSs) or using the sufficient documentation submitted, to resolve the DMI; and 3) who is determined eligible for enrollment in a QHP through the Exchange.

Under the SEP, the individual is able to select new individual coverage through the Exchange. The individual, upon submitting sufficient documentation to resolve their DMI, may request a retroactive effective date to avoid potential gaps in coverage. The retroactive effective date of Exchange enrollment, and APTC and CSR, if applicable, is the day after the effective date of the termination from previous coverage. Alternatively, under 45 CFR 155.420(b)(2)(iii), the individual may also request a prospective effective date of enrollment in the Exchange, for the first of the month following plan selection. The appropriate retroactive effective date of coverage will be appropriately communicated to issuers through Health Insurance Casework System (HICS), if necessary. For

example, an enrollee who had their Citizenship DMI expire who later resolves it is eligible for an SEP to re-enroll in coverage and, if requested, retroactive coverage to close the gap in coverage due to the DMI expiration. The enrollee then contacts the Marketplace Call Center to select a plan under this SEP and request closing the coverage gap. A HICS case is created and directed to the issuer to manually adjust the consumer's coverage effective date due to the resolution of the Citizenship DMI. Issuers should review their records to determine if a prospective enrollment exists before honoring a retroactive enrollment request.

Enrollees who have their eligibility updated due to certain DMIs (for example, annual household income) may experience an adjustment to their eligibility for insurance affordability programs but will remain eligible. The enrollees will continue to be enrolled in coverage through the Exchange with their updated eligibility determination applied. Such enrollees may return to the Exchange and log into their online account to report a change in information that will update their eligibility. The reported changes may result in an updated eligibility determination and may qualify the enrollee for an SEP to make coverage changes.

16. HEALTH REIMBURSEMENT ARRANGEMENTS

16.1 Introduction

Health Reimbursement Arrangements (HRAs) are a type of account-based group health plan that employers can provide to reimburse employees for their medical care expenses.[110] HRAs must comply with certain Patient Protection and Affordable Care Act (ACA) requirements, such as the prohibition on applying an annual dollar limit on essential health benefits (EHB) and providing coverage for preventive services without cost-sharing for these services but are generally unable to comply as standalone HRAs due to the limited nature of the account-based design. Therefore, after enactment of the ACA, employers could only offer an HRA to individuals who were offered another group health plan that did comply with these requirements, provided the HRA met other criteria, unless the HRA qualified as an excepted benefit.

However, in 2019, the Departments of the Treasury, Labor, and Health & Human Services (HHS) jointly published a final rule to permit employers of any size to offer a new type of HRA as of January 1, 2020, called an individual coverage HRA, sometimes referred to as an ICHRA (hereafter referred to as "the 2019 HRA rule").[111] Employees who accept an ICHRA offer, and any covered dependents, must be enrolled in individual health insurance coverage, purchased either on- or off-Exchange; or Medicare Parts A and B, or Part C. It is generally not permissible for such individuals to be enrolled only in short-term, limited-duration insurance (STLDI), or coverage consisting solely of dental, vision, or other "excepted benefits," except as noted below. Among other qualified medical care expenses, ICHRAs can reimburse premiums for qualifying individual health insurance coverage chosen by the employee, thereby promoting flexibility for employees and employers, while also maintaining the same tax-favored status as employer contributions towards a traditional group health plan. Employers have the flexibility to pay their portion of payments directly to issuers, or they may reimburse the employee for substantiated premiums paid by the employee. The 2019 HRA rule also authorizes an additional type of HRA, specifically, one that reimburses certain medical care expenses, such as premiums for excepted benefit coverage (e.g., stand-alone dental or vision coverage).[112] Excepted benefit HRAs may reimburse medical care expenses, such as cost sharing for individual health insurance coverage or group health plan coverage that would not otherwise qualify as excepted benefits, if the conditions of the final rules are satisfied.

Additionally, the 21st Century Cures Act permits small employers who do not offer group health plan coverage to any of their employees to provide a qualified small employer HRA (QSEHRA) to their eligible employees to help employees pay for substantiated medical care expenses. Small employers could provide QSEHRAs for plan years beginning on or after January 1, 2017, or, as of 2020, may offer an ICHRA. An eligible employee can use a QSEHRA to reimburse medical care expenses for themselves and any covered dependents (if permitted by the employer). To receive tax-favored

[110] Medical care expenses are expenses for medical care as defined under section 213(d) of the Internal Revenue Code. See this Internal Revenue Service (IRS) resource at https://www.irs.gov/individuals/frequently-asked-questions-about-medical-expenses-related-to-nutrition-wellness-and-general-health for more information about what qualifies as a medical expense.

[111] See 84 FR 28888.

[112] That is, the excepted benefit HRA may reimburse expenses for excepted benefits, as well as other types of medical expenses that do not qualify as excepted benefits.

reimbursements from a QSEHRA, an employee and any covered dependents must be enrolled in minimum essential coverage (MEC).[113]

16.2 ICHRA and QSEHRA Employer Notice Requirements

The 2019 HRA rule generally requires employers to provide employees who are offered an ICHRA with a written notice at least 90 days before the beginning of the ICHRA plan year. However, for employees who become eligible during the plan year, or later than 90 days before the start of the plan year (such as newly hired employees), employers are required to provide this notice no later than the date on which the employees' coverage under the ICHRA can begin.

This employer notice must include key information about the ICHRA, such as:

- The dollar amount of the HRA offer, including the maximum dollar amount available for each participant including the self-only HRA amount available for the plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage).
- The date that coverage under the ICHRA may begin.
- Whether the offer extends to dependents.
- Contact information (including a phone number) for an individual or group of individuals that employees may contact for additional information regarding the ICHRA.
- A statement of the participant's right to opt out of and waive future reimbursements from the ICHRA.
- A statement that the ICHRA requires the employee and any covered dependents to be enrolled in individual health insurance coverage (or Medicare Part A and B, or Medicare Part C, if applicable), and a statement that the coverage in which the participant and any covered dependents must be enrolled cannot be short-term, limited-duration insurance or consist solely of excepted benefits.
- A statement that if the employee accepts the ICHRA, they cannot claim a premium tax credit (PTC) for their Exchange coverage or for the Exchange coverage of any dependents who are also covered by the ICHRA.
- A statement of availability of a Special Enrollment Period (SEP) to enroll in or change individual health insurance coverage, through or outside of an Exchange, for the participant and any dependents who newly gain access to the ICHRA and are not already covered by the ICHRA.
- A statement that there are different kinds of HRAs (including a QSEHRA) and the HRA being offered is an ICHRA.[114]

Employers that provide QSEHRAs also must provide a notice. Section 9831(d)(4) of the Code requires an eligible employer who provides a QSEHRA to its eligible employees to provide a written notice to each eligible employee at least 90 days before the beginning of each plan year, or for an employee who is not eligible to participate at the beginning of the plan year, the date on which the employee is first

[113] See *Internal Revenue Service (IRS) Notice 2017-67*: https://www.irs.gov/pub/irs-drop/n-17-67.pdf

[114] For more information on this required notice, see the *Individual Coverage HRA Model Notice* at https://www.cms.gov/files/document/hra-model-noticepdf, and/or 45 CFR 146.123(c)(6), 26 CFR 54.9802-4(c)(6), and 29 CFR 2590.702-2(c)(6) or Section 9831(d)(4) of the Code.

eligible to participate in the QSEHRA. This employer notice must include key information about the QSEHRA, such as:

- The dollar amount of the HRA provided.
- The date that coverage under the QSEHRA may begin.
- Whether the provided QSEHRA extends to dependents.
- A statement that the eligible employee must inform any Exchange to which the employee applies for advance payments of the premium tax credit (APTC) of the amount of the provided QSEHRA.
- A statement that if the eligible employee does not have MEC for any month, the employee may be liable for an individual shared responsibility payment under Section 5000A for that month, and reimbursements under the QSEHRA for expenses incurred in the month will be includible in gross income.[115]

16.3 ICHRA/QSEHRA SEP

As of January 1, 2020, employees and their dependents who newly gain access to an ICHRA or who are newly provided a QSEHRA may qualify for an SEP to enroll in individual health insurance coverage through or outside of the Exchange. The triggering event for this SEP is the first day on which coverage for the qualified individual (QI), enrollee, or dependent under the ICHRA can take effect, or the first day on which coverage under the QSEHRA takes effect.

Generally, QIs will need to apply for and enroll in individual health insurance coverage in time for the coverage to take effect by the date that their ICHRA or QSEHRA starts. The Exchange requires individuals who receive their employer notice at least 90 days before the first day of their HRA plan year to apply for coverage and select a Qualified Health Plan (QHP) before their HRA start date in order to qualify for an SEP. For example, an individual whose ICHRA or QSEHRA starts on July 1 and who received their ICHRA or QSEHRA notice at least 90 days ahead of time will need to apply for coverage and select a QHP on or before June 30. Individuals who did not receive their ICHRA or QSEHRA notice at least 90 days ahead of time will be permitted to select a plan up to 60 days before *or after* their HRA start date but should check with their employer in case they need to select a plan sooner to meet their HRA's requirements.

If the individual selects a QHP before the SEP triggering event (the first day on which coverage under the ICHRA can take effect), or the first day on which coverage under the QSEHRA takes effect, then their coverage will take effect on the first day of the month following the date of the SEP triggering event. If the SEP triggering event is on the first day of a month, then coverage takes effect on the date of the SEP triggering event. If the individual selects a QHP on or after the day of the SEP triggering event, coverage will take effect on the first day of the month following plan selection. For more information on the ICHRA/QSEHRA SEP, including relevant 834 codes, see **Section 5**, **Special Enrollment Periods (Applicable to the Individual Market FFE, QHPs/QDPs)**.

Finally, the 2019 HRA rule preamble clarified that HHS will treat individuals with an ICHRA or QSEHRA with a non-calendar year plan year—that is, with a plan year that starts on a day other than January 1—as qualifying for an SEP pursuant to existing rules at 45 CFR 155.420(d)(1)(ii) (the non-calendar year plan year SEP). This SEP applies to QIs and dependents enrolled in a group health plan

[115] For more information on this required notice, see Section E of *IRS Notice 2017-67*: https://www.irs.gov/pub/irs-drop/n-17-67.pdf.

or individual health insurance coverage with a non-calendar year plan year, even if the QI or their dependent has the option to renew the coverage. In addition, while the 21st Century Cures Act Section 18001(c) amends the PHS Act definition of the term "group health plan" to exclude a QSEHRA (except for purpose of Part C Title XI of the Social Security Act [SSA]), the 2021 HHS Notice of Benefit and Payment Parameters final rule amended 45 CFR 155.420(d)(1)(ii) to codify that individuals and dependents who are provided a QSEHRA with a non-calendar year plan year may qualify for this SEP.[116]

16.4 ICHRA/QSEHRA Affordability

Employees and their dependents who are offered an ICHRA are not eligible to receive APTC or PTC if the ICHRA offer is considered affordable. For plan years beginning in 2020, an ICHRA is considered affordable for an employee (and dependents, if applicable) if the monthly premium of the self-only lowest-cost Silver plan[117] available to the employee through the Exchange for the rating area in which the employee resides, minus the monthly self-only amount made available to the employee under the ICHRA, does not exceed the applicable percentage of 1/12 of the employee's household income. The IRS indexes the applicable percentage annually.[118]

For employees and their dependents for whom an ICHRA is not affordable, APTC or PTC is allowed if the employee offered the coverage opts out of the ICHRA and the other APTC/PTC eligibility requirements are met. Employees who are eligible for an ICHRA must be permitted to opt out of and waive future reimbursements on behalf of themselves and all dependents eligible for the ICHRA once each plan year, generally in advance of the first day of the ICHRA's plan year. Participants who become eligible to participate in the ICHRA on a date other than the first day of the plan year or who become eligible fewer than 90 days prior to the plan year, and dependents who newly become eligible during the plan year, must also have an opportunity to opt out of the ICHRA during the applicable ICHRA enrollment period established by the ICHRA for these individuals.

Employees and their dependents who are provided with a QSEHRA are not eligible for APTC or PTC for months in which their QSEHRA is affordable. For plan years beginning in 2017, a QSEHRA is considered affordable for an employee (and dependents, if applicable) if the monthly premium of the self-only second lowest cost Silver plan (SLCSP) available to the employee through the Exchange for the rating area in which the employee resides, minus the monthly self-only amount made available to the employee under the QSEHRA, does not exceed the applicable percentage of 1/12 of the employee's household income.

If the QSEHRA is not affordable, the employee (and dependents, if applicable) is eligible for the APTC or PTC otherwise allowable for the month reduced generally by 1/12 of the employee's permitted benefit under the QSEHRA for the year. Therefore, if the employee (and dependents, if applicable) is determined eligible for APTC, they should consider either foregoing APTC or choosing an amount not more than the APTC for which they are eligible minus the QSEHRA amount provided

[116] 85 FR at 29210–29211: https://www.federalregister.gov/documents/2020/05/14/2020-10045/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021#h-57.

[117] For additional information, please review the ICHRA Employer LCSP Premium Look-Up Table and the associated ICHRA Employer LCSP Premium Look-up Table Data Dictionary, as well as the proposed rule at https://www.cms.gov/marketplace/private-health-insurance/health-reimbursement-arrangements.

[118] The *Applicable Percentage Table for 2026* is available at https://www.irs.gov/irb/2025-32_IRB.

to them. Consumers with a QSEHRA who select more APTC than they are eligible for will likely have to pay some or all of the APTC back when they file their Federal income tax return.

17. Enrollment Community for Contact Management and Inquiries

17.1 Introduction

Communications between the Federally-facilitated Exchange (FFE) and issuers occur on an online platform called the Enrollment Community, which manages issuer email contacts and inquiries and provides:

- Contact management for at least 14 different enrollment-related subscriptions.
- Point of Contact (POC) management for Policy Compliance with Office of Program Operations and Local Engagement Account and Case Managers, such as executive POCs and primary POCs.

FFE issuers, Direct Enrollment/Enhanced Direct Enrollment (DE/EDE) Partners, and third-party administrators (TPAs) who wish to continue receiving email subscriptions must subscribe their contacts in the Enrollment Community.

17.2 Organizations in the Enrollment Community

There are three types of organizations in the Enrollment Community: issuers, TPAs, and DE/EDE partners.[119] Job aids for each of these organization types can be found at https://regtap.cms.gov/reg_library.php (log-in required).

Exhibit 35 lists the two user types for each organization (issuer, TPA, and DE/EDE Partner)

Exhibit 35: User Types

User Type	Description
Administrator (two per organization)	Only administrators can: • Add, change, or remove the five essential points of contact for their organization. • Submit inquiries through the Enrollment Community. • Request access to the Enrollment Community through the CMS Enterprise Portal (special instructions are emailed).
Subscription Contact (unlimited)	Organizations can have an unlimited number of contacts subscribed to each of the different subscription lists (see **Exhibit 36**). Any contact can submit an inquiry via email to a subscription list that has an email address listed in **Exhibit 36**. **Contacts who are not administrators do not need and will not be granted access to the Enrollment Community application.**

Exhibit 36 outlines the subscription lists and the reasons an issuer, TPA, or DE/EDE Partner may want to subscribe to each.

[119] After October 31, 2026, the Classic DE pathway will be retired.

Exhibit 36: Enrollment Community for Contact Management and Inquiries

Subscription List (As of Publication)	Description
Reconciliation	Information about Enrollment Data Reconciliation activities, including Reconciliation Inbound (RCNI) and Reconciliation Outbound (RCNO) files, between issuers and the FFE. **Inquiries**: EnrollmentRecon@cms.hhs.gov
EDE Primary Partners	Information for partners of EDE, which allows partners to provide the full consumer experience of applying, enrolling, and submitting documentations to the Exchange on the partner's site.
EDE Upstream Entities	Information for issuers that are "upstream" of the EDE partner that the issuer works with to offer DE to consumers.
Classic DE Partners	Information for partners and issuers who start and end on the partner's site but apply for eligibility on HealthCare.gov via the classic (or double-redirect) process. **NOTE**: CMS has decided to retire the DE Classic enrollment pathway in advance of open enrollment for plan year 2027.
ALL DE/EDE Partners	General information for all DE and EDE entities and issuers.
Inbound 834 (IC834)	Information about inbound and outbound 834s that issuers and the FFE send and receive to modify enrollments. **Inquiries**: Inbound834@cms.hhs.gov
Enrollment Resolution and Reconciliation (ER&R)	Information about the ER&R process, including the dispute process and HICS (Health Insurance Casework System) Direct Disputes, that issuers use to modify enrollments and information for the issuer or TPA contacts who receive files via Electronic File Transfer (EFT) from the FFE for ER&R purposes. Note that the FFE Data Services Hub (DSH) maintains EFT contacts outside of the Enrollment Community. **Inquiries**: errsupportcenter@cms.hhs.gov
Unmatched "I" Record (UIR)	Information about UIRs (where record of the policy exists with the issuer but not the FFE) discovered by ER&R. The FFE will generally not pay issuers for UIRs. **Inquiries**: UIR@cms.hhs.gov
1095-A	Information for issuers about enrollee 1095-As, including 1095-A disputes. **Inquiries**: 1095aissueroutreach@cms.hhs.gov

Subscription List (As of Publication)	Description
CMS Issuer Communications	General communications and announcements about the FFE for issuers, TPAs, and web-brokers, including upcoming webinar schedules, key deadlines, and open enrollment activities. **Inquiries**: CMS_Issuer_Communications@cms.hhs.gov
Issuer User Acceptance Testing	Information on how to do user acceptance testing during all issuer testing of HealthCare.gov, conducted every autumn. Communication about the status of the issuer testing environment and anticipated downtime, as well as upcoming App3.0 UAT trainings to learn how to access the environment.
Unauthorized Enrollments (UEs)	UEs are enrollments reported to CMS as allegedly made without the enrollee's permission. Issuer contacts who review CMS requests (sent via HICS) to determine whether the enrollment is indeed unauthorized should subscribe to this.
Rescission/Fraud	FFE issuers that wish to cancel enrollments due to fraud must first get the CMS rescission team's concurrence, and information about the rescission process may be shared from time to time via this subscription. CMS may also share information with issuer fraud contacts about changing trends.

18. Policy-Based Payment Two-Phase Audit Approach Overview

18.1 2020 and Future Plan Year Policy-Based Payment Issuer Audits

CMS conducts issuer audits of data supporting the advance payments of the premium tax credit (APTC) and Federally-facilitated Exchange (FFE) user fees (UFs) calculated under CMS's automated payment system, policy-based payment (PBP). Beginning in 2023, CMS implemented a two-phased audit approach for all future plan year PBP issuer audits.

First, the audit approach consists of the execution of the Enrollment Policy Audit sampling reviews (Phase 1), in which CMS examines issuer compliance with premium payment regulations such as 45 CFR 155.400(e) and 45 CFR 156.270(g). These policy reviews take place during the three-year dispute window set forth in 45 CFR 156.1210(c) to provide more real-time compliance insights and improvement. Second, following the end of the three-year dispute window, CMS executes the Enrollment Reconciliation and Payment Audit (Phase 2), consisting of Reconciliation Outbound (RCNO) file reviews of FFE and issuer data mismatches to identify CMS overpayments and underpayments made to issuers resulting from issuer or CMS reporting errors. The execution of Phase 2 audits after the three-year dispute window aims to preserve the ability for issuers to timely resolve and reconcile disputes prior to audit adjustments, while executing the Phase 1 policy reviews in the year after the applicable plan year provides issuers with timely compliance feedback for addressing premium payment policy observations or violations. The execution of plan year Phase 1 audits will occur separately and during an earlier calendar year from the execution of the plan year Phase 2 audits, which will occur after the end of the three-year dispute window. Issuers selected for a Phase 1 audit may also be selected for a Phase 2 audit of the same plan year.

As CMS noted in the Payment Policy and Financial Management Group External Audit Communication letter dated July 19, 2019, consistent with the expiration of the good faith policy at 45 CFR 156.800(c), CMS may impose civil money penalties (CMPs) for findings identified beginning with 2020 plan year audits.[120] CMS issued preliminary and final CMP notices for 2021 plan year Enrollment Policy Audit (Phase 1) violations and intends to continue to issue CMPs for subsequent plan year Phase 1 audit violations.

18.2 Other Audits

CMS also audits FFE issuers on other topics, including the following:

- Medical Loss Ratio (MLR) Examinations
- Federal Market Conduct Examinations – Market-wide requirements, including Qualifying Payment Amount Audits
- Mental Health Parity Non-Quantitative Treatment Limitation Comparative Analysis Reviews
- CO-OP Compliance Reviews
- High-Cost Risk Pool (HCRP) Audits
- Risk Adjustment Data Validation (RADV) Audits

[120] https://www.cms.gov/files/document/ppfmgea-audit-communication-non-auditees5cr071819.pdf

Selection and scheduling of PBP and other audits is coordinated within CMS, and CMS also works with state regulatory agencies to coordinate oversight activities, as applicable. For more information on these CMS audits, refer to https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Exams_Audits_Reviews_Issuer_Resources-.

19. 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?

1. **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.
2. **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.
3. **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.
4. **Information about other coverage (If applicable)** – Provides information about additional coverage such as dental or vision coverage, and health club membership discounts.
5. **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 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
[Insert name]	Birchwood Health Plan	[Date]
[Insert name]	Birchwood Health Plan	[Date]

Benefits may change from year to year. You will be notified of these changes before the Open Enrollment Period. You can change plans during the Open Enrollment Period or if you qualify for a Special Enrollment Period.

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

Where can I find additional resources?

You can contact us by phone at the numbers that follow, 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.

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 help desk at 1-xxx-xxx-xxxx Monday through Friday from 8:00 a.m. to 8:00 p.m. ET or Saturday and Sunday from 9:00 a.m. to 5:00 p.m. 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 8:00 a.m. to 8:00 p.m. ET or Saturday and Sunday from 9:00 a.m. to 5:00 p.m. ET.

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

Sincerely,

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

[Insert privacy disclosure and nondiscrimination notice language]

20. 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 $[amount] by [due date].

Since you are getting advance payments of the premium tax credit to help pay for your insurance, you have a three-month grace period to pay your outstanding premium and any new premiums that accrue during this period before your insurance coverage will end. Please be aware that your provider may pend claims for any services you receive during the second and third months of the grace period because your provider may seek to bill you for the services directly if your coverage is terminated for failure to pay your premiums. 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 Birchwood Health Plan coverage will be terminated back to [date]. If you wait until the final day 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.

When will I be able to enroll in another health insurance plan if my coverage ends?

You can select a Qualified Health Plan for enrollment through the Marketplace during the next annual Open Enrollment Period.

If your circumstances change 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, among other things, 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 8:00 a.m. to 8:00 p.m. ET or Saturday and Sunday from 9:00 a.m. to 5:00 p.m. ET.

Sincerely,

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

[Insert privacy disclosure and nondiscrimination notice language consistent with 45 CFR 156.250]

21. 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. [insert name] and [insert name] will no longer have health insurance coverage from Birchwood Health Plan on [insert termination effective date], because you requested that Birchwood terminate your insurance. You requested to terminate your insurance by [insert description—e.g., calling our help desk on July 20, 2023].

The table 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
[insert name]	Birchwood Health Plan	[insert termination effective date]	[insert reason—e.g., Requested to terminate coverage]
[insert name]	Birchwood Health Plan	[insert termination effective date]	[insert reason—e.g., 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 your coverage ends. 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.

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

You can select a Qualified Health Plan through the Health Insurance Marketplace® website at www.HealthCare.gov during the next annual Open Enrollment Period.

If your circumstances change during the year, like your family size (for example, if you marry, divorce, or have a child), your income, or if you move, among other things, you may be eligible for a

Special Enrollment Period to enroll in coverage before the annual enrollment period. You 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. 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 help desk at 1-xxx-xxx-xxxx Monday through Friday from 8:00 a.m. to 8:00 p.m. ET or Saturday and Sunday from 9:00 a.m. to 5:00 p.m. ET.

Sincerely,

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

[Insert privacy disclosure and nondiscrimination notice language consistent with 45 CFR 156.250]

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22. APPENDIX D – SAMPLE PLAN DISPLAY ERROR NOTICE

Birchwood Health Plan

[Date]

[Insert name]
[Insert address]

Dear [Insert name],

Important information regarding your [plan year] health coverage

Thank you for enrolling in [insert plan] with Birchwood Health Plan for your [plan year] health coverage. You're getting this letter because we displayed erroneous plan information when you enrolled in our plan on HealthCare.gov. This means that [describe the practical impact of errors on consumers].

The table provides an explanation of what was inaccurately displayed and what the correct plan information is.

Benefit	Information Originally Displayed on HealthCare.gov	Updated Information
[benefit name]	[inaccurate benefit information]	[correct benefit information]

You can change to another plan.

Because of this error, you qualify for a Special Enrollment Period (SEP) to enroll in another plan if you choose. The opportunity to change plans ends 60 days from the date on this letter.

You have options for your coverage:

1. **Do nothing to stay in your plan.**
   If you're happy with your plan, you don't have to leave.
2. **Pick another plan with the same insurance company.**
   Select the new plan with Birchwood Health Plan through the Marketplace and start paying premiums for your new coverage.
3. **Pick a different plan through the Marketplace.**
   Select the new plan with a different issuer through the Marketplace and start paying premiums for your new coverage.

You can choose to have your coverage start either the first of the month after you choose a new plan or back to when your coverage with Birchwood Health Plan started.

- **Coverage starts the first of the next month** – You won't get a refund for premiums you already paid to your current plan.

    - If you pick a plan with Birchwood Health Plan, any costs you paid towards your deductible and annual maximum out-of-pocket limit [choose one: will transfer or will not transfer] to your new plan.
    - If you pick a plan with a new insurance company, any costs you paid towards your deductible and annual maximum out-of-pocket limit won't transfer to your new plan. You'll start paying premiums for your new coverage, and you'll also have to restart any payments you made towards the plan's deductible and annual maximum out-of-pocket limit.
- **Coverage starts back to when your current plan coverage started** – We'll reverse all claims we've processed for services you got while in your current plan and refund any premiums you paid. Your newly selected plan will collect your new portion of the premium and is responsible for all covered services.
    - If you pick a plan with Birchwood Health, any costs you paid toward your deductible and annual maximum out-of-pocket limit [choose one*:* will transfer or will not transfer] to your new plan. Additionally, we will apply your refunded premium to the premium for your new plan, and we will reprocess all claims we've processed for services you got while in your current plan under your new plan.
    - If you pick a plan with a new insurance company, any costs you paid toward your deductible and annual maximum out-of-pocket limit won't transfer to your new plan. You'll start paying premiums for your new coverage, and you'll also have to restart any payments you made toward the plan's deductible and annual maximum out-of-pocket limit. You will also need to pay back premiums to your new insurance company back to your original plan's start date.

You have two options to change plans:

1. Call the Marketplace Call Center at **1-800-318-2596** (TTY: 1-855-889-4325). They can help you with your coverage options regardless of which coverage start date you pick. Please note if you want your coverage to start when your current plan coverage began, you *must* call the Marketplace Call Center.
2. If you elect for coverage to start the first of the next month, you have the additional option to make a new plan selection via HealthCare.gov (or where you selected your current plan). To do so, navigate to where you selected your current plan, log into your account, and update your [plan year] application. Once you update and submit your [plan year] application, you will be eligible to make a new plan selection.

[Optional Information to Include]

Important notes about changing plans:

- If you previously received services and want to keep your healthcare providers, you should make sure that those providers are covered in your new plan's network before enrolling in that new plan. The services may be more or less expensive, even with the same providers, depending on which new plan you select.
- For your new coverage, you must pay at least the first month's premium in order for your new coverage to begin. You will still be responsible for any co-pays or deductibles for healthcare services under your current coverage until your new coverage effective date.

We apologize for any inconvenience.