Date: March 26, 2014

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

Title: Affordable Exchanges Guidance

Subject: Guidance for Issuers on Special Enrollment Periods for Complex Cases in the Federally-facilitated Marketplace after the Initial Open Enrollment Period

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CMS will provide the following special enrollment periods for consumers to enroll in Marketplace coverage after open enrollment closes on March 31. These special enrollment periods include special enrollment periods the Federally-facilitated Marketplace (FFM) is currently processing that allow a consumer to select a plan outside of the open enrollment period, including life changes, benefit display errors, misrepresentation and some exceptional circumstances. Special enrollment periods are authorized under 45 CFR 155.420.

The special enrollment periods in the chart below represent categories of individuals that CMS has determined eligible for an special enrollment period under paragraphs (d)(4), (d)(9), and (d)(10) of 45 CFR 155.420. Categories that warrant special enrollment periods may be added in the future if other appropriate circumstances, as determined by CMS, become known.

Limited Circumstance Special Enrollment Periods	Description	Examples
Exceptional Circumstances	A consumer faces exceptional circumstances as determined by CMS, such as a natural disaster, medical emergency, and planned system outages that occur on or around plan selection deadlines.	• A natural disaster, such as an earthquake, massive flooding, or hurricane. • A serious medical condition, such as an unexpected hospitalization or a temporary cognitive disability • A planned Marketplace system outage, such as SSA system outage
Misinformation, Misrepresentation, or Inaction	Misconduct by individuals or entities providing formal enrollment assistance (like an insurance company, Navigator, certified	• Representative enrolled a consumer in a plan that the consumer did not want to enroll in

	application counselor, Call Center Representative, or agent or broker) resulted in one of the following: • A failure to enroll the consumer in a plan • Consumers being enrolled in the wrong plan against their wish • The consumer did not receive advanced premium tax credits or cost-sharing reductions for which they were eligible.	
Enrollment Error	Consumers enrolled through the Marketplace, but the insurance company didn't get their information due to technical issues.	• Consumer's information is received by the insurance company and may be processed, but the enrollment file contains defective or missing data which makes the insurance company unable to enroll the consumer. • Consumer's application may have been rejected by the issuer's system because of errors in reading the data.
System errors related to immigration status	An error in the processing of applications submitted by immigrants caused the consumer to get an incorrect eligibility result when they tried to apply for coverage.	• Immigrants with income under 100% of the poverty line who are eligible for premium tax credits and cost-sharing reductions did not receive the proper determination.
Display Errors on Marketplace website	Incorrect plan data was displayed at the time the consumer selected the QHP, such as plan benefit and cost-sharing information.	• Data errors on premiums, benefits, or co-pay/deductibles. • Errors that resulted in the display of a QHP to applicants that were outside of the QHP's service area or that were in ineligible enrollment groups. • Errors that didn't allow consumers with certain categories of family relationships to enroll together in a single plan with their family members.
Medicaid/CHIP - Marketplace transfer	Consumers who were found ineligible for Medicaid or CHIP and their applications weren't transferred between the State Medicaid or CHIP agency and the Marketplace in time for the consumer to enroll in a plan during open enrollment.	• Consumers, who applied at the FFM, were assessed eligible for Medicaid or CHIP, were found ineligible for Medicaid or CHIP by the state agency and then weren't transferred back in time for an FFM determination during open

		enrollment. • Consumers who applied at the state Medicaid or CHIP agency during open enrollment and ended up having their cases referred to the Marketplace after a denial of Medicaid or CHIP.
Error messages	A consumer is not able to complete enrollment due to error messages.	• Error or box screen indicating that the data sources were down and they could not proceed with enrollment.
Unresolved casework	A consumer is working with a caseworker on an enrollment issue that is not resolved prior to March 31st.	• Consumers who began the case work process but it was not resolved prior to the end of open enrollment.
Victims of domestic abuse	A consumer who is married, and is a victim of domestic abuse. Consumers who are in this category can apply and select a plan through May 31, 2014.	• Prior to clarifying guidance from Treasury and HHS, consumer assumed or was informed that APTC were unavailable to consumers who are married and not filing a joint tax return. Consumer may or may not have attempted to apply.
Other system errors	Other system errors, as determined by CMS, which hindered enrollment completion.	

Generally, CMS has determined that these special enrollment periods will result in prospective coverage effective dates.[1] For the SEPs addressed here, 45 CFR 155.420(b)(2)(iii) allows for SEP coverage effective dates to be based on either the date of the event that triggered the SEP or the regular prospective effective dates described under 45 CFR 155.420(b)(1), in accordance with guidelines issued by HHS. In cases where it is unknown when a consumer would have effectuated coverage, CMS believes that providing coverage according to the regular effective dates is appropriate.[2]

[1] See 155.420(b) and 155.420(b)(2)(iii)(B).

[2] CMS has no way to definitively know when a consumer impacted by these errors would have effectuated coverage had they not faced the barrier triggering the SEP since there are various steps that need to occur after plan selection before coverage is effectuated (i.e., paying premiums).