Health Advocate

E-Newsletter of the National Health Law Program

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Special Enrollment Periods

Prepared by: Sonal Ambegaokar

Key Resources

45 C.F.R. 155.420, available here.

26 C.F.R. 9801-6, available here.

SEP "Complex Case" guidance, available here.

SEP COBRA guidance, available here.

SEP for Survivors of Domestic Violence, available here.

SEP for losing PCIP, available here.

Coming in May's Health Advocate:

Older Adults

While almost eight million individuals enrolled through the federal and state marketplaces during open enrollment, many more may have missed the opportunity for a variety of reasons. However, consumers may be able to enroll before the next open enrollment period (November 15, 2014 – February 15, 2015) either through a special enrollment period (SEP) for marketplace coverage or year round enrollment in Medicaid and CHIP. This issue of the Health Advocate provides an overview of the current eligibility rules for special enrollment periods (SEPs) for marketplace coverage.

Why are SEPs important?

Without SEPs, individuals who missed open enrollment (and are not Medicaid or CHIP eligible) could remain uninsured for the remainder of the year. A SEP can help individuals get access to affordable health care now and, if not otherwise exempt, avoid a tax penalty for not having coverage. Because the tax penalty is prorated, individuals who enroll for some portion of the year can reduce the amount of their tax penalty.

Because the Affordable Care Act (ACA) prevents health insurance plans from denying individuals coverage for pre-existing conditions, insurers want to limit enrollment to open and special enrollment periods to prevent adverse selection, assuming individuals seeking to enroll are doing so only because they are in need of care at that moment. Yet healthy and unhealthy individuals alike may need to obtain coverage outside of open enrollment because they may lose existing coverage or experience other life changes. Because insurance companies prefer enrollment limits while consumers need flexibility to account for unanticipated changes, policymakers must balance these competing goals when implementing SEPs.

Who qualifies for SEP?

Currently, federal regulations authorize **eleven** specific special enrollment periods (SEPs), or qualifying events, that every marketplace—whether state-based or federally facilitated—must provide consumers.[1] Along with these federally required SEPs, state based marketplaces may create additional SEPs to provide further protections to consumers. For example, California's state-based marketplace, Covered California, created a SEP for military reservists returning from active duty. Finally, as discussed in

[1] 45 C.F.R. § 155.420.

detail below, the federally facilitated marketplace (FFM) has announced specific situations that qualify as a SEP based on "exceptional circumstances." In general, the currently available SEPs fall under four broad categories:

- Loss of minimum essential coverage;
- Changes in life circumstances;
- Enrollment problems; and
- Exceptional circumstances.

A. *Loss of minimum essential coverage*

If an individual has "minimum essential coverage" (MEC) which is canceled, involuntarily terminated, or otherwise ends before January 2015, an individual can enroll in the marketplace and qualify for premium tax credits under a SEP in 2014.[2] Losing job-based coverage (even if the job loss is voluntary) is a common example of a loss of MEC that triggers an SEP.

The key to this SEP is that the coverage that is ending must be considered "minimum essential coverage." If the individual's coverage is not considered MEC, an individual is not eligible for a SEP, regardless of the reason for the loss of coverage. This SEP also requires that the loss of MEC be involuntary. An individual is not eligible for this SEP if he: a) voluntarily cancels MEC; b) fails to pay premiums causing MEC to be terminated by the insurance plan; or c) commits fraud allowing an insurance plan to rescind coverage.

Because Medicaid and CHIP are generally considered MEC, if a beneficiary's coverage is terminated, he would qualify for a SEP due to a loss of MEC. Yet if a beneficiary loses Medicaid coverage that is not considered MEC, he is not eligible for a SEP. For example, the following Medicaid programs are not considered MEC: emergency only, pregnancy-related (although proposed regulations would grant an SEP upon termination of pregnancy-related coverage), family planning, tuberculosis, and Medicaid demonstration waivers under Section 1115 of the Medicaid Act.

B. *Changes in life circumstances*

Certain changes in life circumstances also trigger a SEP. Examples include turning 26 years old (and no longer being eligible as a dependent on parents' coverage), moving to another region or state that has different insurance plans, or adding a dependent—either through birth, adoption or foster care placement, or through marriage or domestic partnership. However, other changes in life circumstances—such as divorce or death—also require an individual to have experienced a loss of MEC as a result of the life change to qualify for a SEP.

C. *Enrollment problems*

An individual may qualify for a SEP if she was unable to enroll in the marketplace during or after open enrollment because of enrollment barriers. For example, an individual may qualify for a SEP if she was not enrolled in the plan of her choice due to "error, misrepresentation, or inaction" of an official or agent of the marketplace, misconduct by a "non-Exchange entity," or a material violation of the contract by a plan.

Due to the numerous enrollment barriers consumers faced when they attempted to apply through http://www.healthcare.gov during the initial open enrollment period, the Centers for Medicare and Medicaid Services (CMS) announced two SEPs specifically related to enrollment barriers. First, individuals who were otherwise "in line" to enroll prior to March 31 received a SEP to complete enrollment by April 15 (April 30 for

[2] 26 C.F.R. 9801-6; 45 C.F.R. § 155.420(e).

paper applications). A SEP was also granted to individuals with "complex cases," who, for example, experienced computer or system errors, or enrolled based on misinformation by official enrollment assistors, such as call center service representatives, agents, or brokers. The "complex cases" SEP explicitly includes individuals referred to Medicaid or CHIP who were found ineligible (and thus eligible for the marketplace) but did not receive the Medicaid or CHIP denial until after open enrollment ended.

D. Exceptional Circumstances

State based marketplaces as well as the FFM may grant a SEP based on "exceptional circumstances" to account for a unique or unanticipated circumstance that is not already identified as a qualifying event, but still warrants a SEP. A SEP based on exceptional circumstances can apply to a group of individuals who meet certain requirements or to an individual on a case-by-case basis. CMS has identified the following SEPs for the FFM based on exceptional circumstances, which state based marketplaces may also choose to adopt:

- Losing eligibility for a hardship exemption;
- Surviving domestic violence (available until May 30, 2014);
- Losing coverage from the Pre-Existing Condition Insurance Program (PCIP) after April 30, 2014 (available until May 1, 2014);
- Seeking to terminate COBRA (available until July 1, 2014);
- Losing coverage from individual market plans which end between open enrollment periods and will not be renewed; and
- Starting or ending service in the AmeriCorps State and National, VISTA or NCCC programs.

Applying for a SEP?

To enroll in coverage under a SEP, consumers must first be found eligible for a SEP by the FFM or state-based marketplace per the guidelines outlined above. Consumers may apply for a SEP from the FFM through the healthcare.gov website or the call center. If approved for a SEP, an individual can enroll in a marketplace plan under existing enrollment procedures. An individual who is found ineligible for a SEP may file an appeal with the marketplace that issued the decision.

Consumers must generally apply for a SEP within 60 days of the qualifying event (e.g., the loss of MEC or the birth of a child). To avoid confusion and ensure consumers understand this deadline, marketplaces should provide clear notice as to the date the 60-day clock to apply for a SEP starts for each qualifying event. Under proposed regulations, an individual may apply for a SEP prior to the date of certain qualifying events rather than applying after the event occurs to avoid a potential gap in coverage. Once the marketplace approves an individual's request for a SEP and provides notice to the consumer, she may enroll in any participating marketplace plan of her choice and apply for premium tax credits and cost-sharing reductions, just as during open enrollment.

Coverage in a SEP must begin within two months of completing plan enrollment. The date that coverage begins (the effective date) for most qualifying events will depend on whether plan enrollment was completed before or after the 15th of the month. However, if a SEP is based on a birth, adoption, or foster care placement, coverage must *begin the date of that event*—regardless of when plan enrollment was completed. In addition, if a SEP is based on marriage, domestic partnership, or loss of MEC, coverage in a SEP must begin the *1st of the month after the date of marriage or the date MEC ended*—also regardless of when plan enrollment was completed. If a SEP is based on

"exceptional circumstances" or enrollment errors, coverage could be granted retroactively because the effective date must be "an appropriate date based on the circumstances of the special enrollment period."[3]

Conclusion

Since Medicaid and CHIP enrollment continues year round and some consumers can also receive SEPs, the focus on enrollment for this initial year of the ACA is not over. Because individuals in all income levels routinely experience changes in life circumstances, a SEP helps these individuals avoid gaps in coverage and the tax penalty for lack of coverage. Ensuring SEPs are implemented in a consumer-friendly manner will help connect individuals to coverage when life happens, not solely during the official open enrollment period.

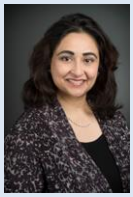
About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

Author

The following NHeLP attorney contributed to this month's *Health Advocate*:

Sonal Ambegaokar
Senior Attorney
LA Office



Offices

Washington, DC
1444 I Street NW, Suite 1105
Washington, DC 20005
(202) 289-7661
nhelpdc@healthlaw.org

Los Angeles
3701 Wilshire Blvd, Suite 750
Los Angeles, CA 90010
(310) 204-6010
nhelp@healthlaw.org

North Carolina
101 East Weaver Street, Suite G-7
Carrboro, NC 27510
(919) 968-6308
nhelpnc@healthlaw.org

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[3] 45 C.F.R. § 155.420(b)(2)(iii) (2014).