FAQs on Special Enrollment Periods For the Individual Marketplace

1. **Can I enroll in a health plan or change my health plan after February 15, 2015?**
   Open enrollment for NY State of Health ended on February 15, 2015. The next open enrollment period begins on November 1, 2015. There are only two situations that would allow you to enroll in a health plan, change metal levels within a health plan/insurer or switch health plans, between now and the next open enrollment period:
   - If you are eligible for Medicaid or Child Health Plus or are an employer enrolling through the Small Business Marketplace, you can enroll in those programs year-round.
   - If you are eligible for a qualified health plan (QHP) and you are also eligible for a Special Enrollment Period (SEP), you can enroll in or change QHPs during your SEP.

   If you are QHP eligible but do not qualify for an SEP, you may not enroll in or change health plans until the next open enrollment period beginning November 1, 2015 for coverage effective January 1, 2016. There are no exceptions to this rule.

   These SEP rules only apply to the Individual Marketplace and do not apply to the Small Business Marketplace.[1]

2. **Who is eligible for a Special Enrollment Period?**
   You must have one of the reasons described below to be eligible for a Special Enrollment Period (SEP). If one person in your household is eligible for an SEP, everyone in your household who is eligible for or enrolled in a QHP through NY State of Health gets an SEP. Unless otherwise noted below, health coverage begins after you select your health plan. If you enroll in or change your health plan on or before the 15th day of a month, coverage starts the 1st day of the next month. If you enroll in or change your health plan after the 15th, coverage will begin on the 1st day of the month following the next month, which is generally about 6 weeks later. NY State of Health refers to these as the *regular effective dates* for health coverage to begin.

[1] Rules for the Small Business Marketplace can be found in the NYS Department of Financial Service Model Contract Language for "Group – Who is Covered." This information is available online: http://www.dfs.ny.gov/insurance/health/model_lang_indx.htm

Marriage or Domestic Partnership[2]

You have 60 days from the date of the event to select a health plan. Your coverage start date will automatically follow the rules for regular effective dates, but you may opt to start coverage the first of the month following the event by contacting the NY State of Health at 1-855-355-5777.

Birth, Adoption or Placement for Adoption, or Placement in Foster Care

You have 60 days from the date of these events to select a health plan. Your coverage start date will automatically follow the rules for regular effective dates, but you may opt to start coverage on any of the following dates by contacting the NY State of Health at 1-855-355-5777: 1) date of the event; 2) first of the month after the event; 3) first of the month after plan selection if that is after the first two options; 4) first of the following month after plan selection if that is later than the first two options. If your family is applying for coverage for the first time and has an SEP for one of these events, the coverage start date for your entire family will be the same.

Becoming a Citizen, National or Lawfully Present Individual

These events make you eligible for an SEP. You have 60 days from the date of the event to select a health plan.

Changing from one of these three status types to another (such as formerly being a Legal Permanent Resident and becoming a Naturalized Citizen) will not make you eligible for an SEP. This SEP is intended to allow individuals who were not previously QHP eligible due to immigration status to enroll once they become QHP eligible. Therefore, if you were eligible to enroll in a QHP during Open Enrollment but chose not to do so, you will not be eligible for this SEP.

Change in Eligibility for Financial Assistance

- If you are enrolled in a QHP and become newly eligible or ineligible for tax credits, or if you have a change in eligibility for cost-sharing reductions (CSR), you are eligible for an SEP. You have 60 days from the date of your new eligibility determination to select a new health plan. (There are different levels of CSR, depending on income. Changing levels or becoming eligible or ineligible for CSR levels qualifies you for this SEP.)

[2] As defined in the NYS Department of Financial Services Model Language, Domestic Partnership is attained when a couple has obtained proof of the domestic partnership and financial interdependence through:

- a Domestic Partner Registration, if available; or
- An Alternative Affidavit of Domestic Partnership. This must be notarized and contain proof of cohabitation and financial interdependence. Applicants who live in cities or counties that do not offer registration should contact the health plan directly for all of the requirements the affidavit should contain.

NYSOH is providing the above definition to clarify the definition of Domestic Partnership, but the Marketplace does not require consumers to submit proof of Domestic Partnership with their application for coverage.

- If you were eligible for Cost Sharing Reductions (CSR) at one level but opted to forgo the CSR benefit by enrolling in a non-Silver plan, and then had a change in income that made you eligible for a different level of CSR benefits, you would be eligible for an SEP.
- If you are enrolled in a QHP with tax credits and become eligible for a different amount of tax credits, you can adjust the amount of tax credits you apply towards your premium each month but you are not eligible for an SEP. The new APTC amount will go into effect the first day of the following month.
- If you are enrolled in a QHP and become eligible for Medicaid or Child Health Plus you can enroll year-round in those programs and do not need an SEP to do so.

Permanent Move

If you have permanently moved to New York State, or if you have permanently moved from one county to another within the State and gain access to new QHPs as a result of the move, you are eligible for an SEP. You have 60 days from the date of your move to select a health plan. Your coverage start date will automatically follow the rules for regular effective dates, but you may opt to start coverage the first of the month following the event by contacting the NY State of Health at 1-855-355-5777.

If one member of your coverage household is eligible for an SEP through a permanent move, all members of your coverage household who remain at your original address who are eligible for or enrolled in a QHP will also be eligible for an SEP.

No Longer Incarcerated

If you were previously incarcerated and have been released, you are eligible for an SEP. You have 60 days from the date of your release to select a health plan. Your coverage start date will automatically follow the rules for regular effective dates, but you may opt to start coverage the first of the month following the event by contacting the NY State of Health at 1-855-355-5777.

Loss of Health Coverage

If you lose your health coverage you might be eligible for an SEP if the health plan you had gave you minimum essential coverage. Minimum essential coverage is the type of coverage you need to meet the Affordable Care Act requirement that you have health insurance. This includes individual market policies, job-based coverage, Medicare, Medicaid, Child Health Plus, TRICARE and certain other coverage. If you had limited coverage – such as a hospital-only policy or a prescription-only policy – you did not have minimum essential coverage and loss of that limited coverage policy does not make you eligible for an SEP.

You are not eligible for an SEP if you voluntarily end your coverage or if you lose your coverage because you did not pay your premiums on time.

If you know in advance that you are going to lose your health coverage, you may apply for an SEP up to 60 days before you lose health coverage; you have 60 days from the date you

lose coverage to enroll in a health plan. Your coverage start date will automatically follow the rules for regular effective dates, but you may opt to start coverage the next immediate month or the first of the month following the event by contacting the NY State of Health at 1-855-355-5777.

Here are some common examples of why someone could lose health insurance and become eligible for an SEP.

- Loss of Job-Based Insurance
  - If you had insurance through your job and you lost your job (voluntarily or involuntarily), you are eligible for an SEP
  - If you had insurance through your job and your employer stops offering health insurance coverage, you are eligible for an SEP
  - If you had insurance through your job and you are no longer eligible for insurance through your job, you are eligible for an SEP
  - If you had insurance through your job and your insurance is no longer affordable or is no longer minimum essential coverage, and you are otherwise eligible for financial assistance, you are eligible for an SEP

- The plan year ends for non-group coverage purchased outside of the Marketplace

- Aging out of Coverage

- Divorce, Annulment, Legal Separation or End of Domestic Partnership

- Death of a Spouse

- No Longer Eligible for Medicaid or Child Health Plus
  - If you are renewing your enrollment in Medicaid or Child Health Plus and, as a result of changes in eligibility, you become eligible for a QHP through the Marketplace, you are eligible for an SEP.
  - Medicaid and Child Health Plus have continuous coverage for 12 months. Even if your income changes during this time, you can remain covered through Medicaid or Child Health Plus.

- COBRA Coverage is Terminated
  - If your COBRA benefits have expired, you are eligible for an SEP.
  - If your COBRA benefits ended because you did not pay your premiums in a timely manner, you are not eligible for an SEP.
  - If you enrolled in COBRA but no longer want it, you are not eligible for an SEP until your COBRA coverage has ended.

- Health Plan is No Longer Available[3]

Facing a 2014 Tax Penalty

If you had to pay a federal penalty for 2014 and were not aware or did not understand that you would have to pay a penalty for not having health insurance coverage, there is a time limited SEP that allows you to enroll in a QHP.

The SEP will end at 11:59 p.m. on April 30, 2015. To be eligible for this SEP, you must attest that when you filed your 2014 federal tax return, that you paid a penalty for not having health insurance in 2014, and that you first became aware of or understood the implications of not having health insurance in 2014 when you filed your federal tax return.

American Indian/Alaskan Native

If you are an American Indian or Alaskan Native, you are eligible for an SEP that allows you to enroll in a health plan or change from one health plan to another once per month.

Additional Reasons You Could be Eligible for a Special Enrollment Period

If you experience one of the following types of events, you may be eligible for an SEP. Please call NY State of Health at 1-855-355-5777 for more information:

- A child support or other court order
- An enrollment error due to Marketplace staff or contractor error, misrepresentation, misconduct, or inaction
- Health plan violated a material provision of its contract
- Other exceptional circumstances as defined by the U.S. Department of Health and Human Services

3. How do I request a Special Enrollment Period?

If you are not enrolled in NY State of Health, you must complete the Marketplace application to request an SEP. If you are already enrolled in a health plan through the Marketplace you may request an SEP by updating your Marketplace application. Consumers may complete or update their application online at www.nystateofhealth.ny.gov, by phone through the NY State of Health Customer Service Center at 1-855-355-5777, or with an in-person assistor.

Before submitting your application, you will be asked why you are requesting new coverage or a change in coverage. If you meet the SEP eligibility criteria you will be allowed to enroll in a health plan. If you do not meet the eligibility criteria, or have missed the 60 day window to select a health plan, you will have to wait until the next Open Enrollment Period to enroll in coverage.

[3] You will not be eligible for an SEP to enroll in or change plans if your provider does not participate in, or stops participating with, your health plan during the plan year. If your prescription formulary changes during the plan year, you will not be eligible for an SEP to enroll in or change plans..

If you are requesting an SEP for one of the Additional Reasons listed below, please call NY State of Health at 1-855-355-5777:

- A child support or other court order
- An enrollment error due to Marketplace staff or contractor error, misrepresentation, misconduct, or inaction
- Health plan violated a material provision of its contract
- Other exceptional circumstances as defined by the U.S. Department of Health and Human Services

When requesting an SEP, you will be required to attest to the truthfulness of the information on your application and the reason why you are requesting an SEP. There may be instances in which NY State of Health will request documents to validate the information provided in your application, but in most cases, you will not need to submit documentation in order to request an SEP.

4. <u>If I enroll in or change health plans during an SEP, what do I need to know?</u>

If you are already enrolled in a health plan and are eligible for an SEP, you can change health plans but you do not have to. You can choose to stay in your current plan.

If you decide to change plans, you will start over with a new deductible and out of pocket limit for the new health plan. Your spending towards the deductible and maximum out of pocket limit from your old health plan will not carry over to the new health plan.

If you enroll in a health plan mid-year, you will need to meet the whole deductible and out of pocket limit as if you were enrolled in the health plan for a full 12 months. Deductibles and maximum out of pocket limits are not pro-rated based on the length of enrollment.

<u>SEPs and Stand Alone Dental Coverage</u>

If you enroll in or change QHPs through an SEP, you may also enroll in or change stand alone dental plans (SADPs).

<u>Deductibles and Out of Pocket Maximums</u>

All QHPs have Out of Pocket Maximums, which is the maximum amount that you may have to pay in out of pocket costs (co-pays, cost-sharing, deductibles) for covered services during the year. Some QHPs have an annual deductible which is the amount that you have to pay out of pocket for covered services before the QHP pays for claims. Spending towards a deductible counts towards the Out of Pocket Maximum.

If you enroll in a QHP mid-year or change plans mid-year you may have to meet the entire deductible and out of pocket maximum as if you were enrolled in the QHP for a full 12 months. An SEP allows, but does not require, a current enrollee to change plans. We offer the following scenarios in which someone might change plans or not change plans, and the impact the decision has on deductibles and out of pocket limits.

Change in CSR benefits

Jane is enrolled in a Silver plan with CSR benefits and becomes ineligible for CSR benefits. She has contributed $500 towards her $1000 deductible in the Silver plan with CSR benefit. Jane has two options:

(1) Stay with the exact same QHP without the Cost-Share Reduction benefits. If Jane chooses this option, the $500 she already spend towards her deductible will carry over to that plan.

(2) Pick a different plan that had a $2,000 deductible. If Jane chooses this option, the $500 she already spent towards her deductible will not carry over to the new plan and she would have to meet the entire $2,000 deductible by the end of the calendar year in order for the health plan to begin covering her benefits.

Adding a new family member

Jane and Jaime are enrolled in a QHP. Jane and Jamie spent $500 towards their $1000 deductible. Jane gives birth to Alex, giving all three family members an SEP. This three person household has an income of more than 400% FPL. Jane and Jaime have four options to cover Alex:

1) Alex can enroll in a full cost Child Health Plus (CHP) plan
   CHP has no out of pocket costs. If Jane and Jaime stay in their existing QHP, they carry forward the $500 they already spent towards their deductible and out of pocket costs. If Alex were to enroll in CHP, Jane and Jaime could still switch to a new QHP, but they would have to meet the new deductible amount and maximum out of pocket limit as if they were enrolled in the plan for the full 12 months. The $500 that Jane and Jaime already spent under their old plan would not carry over to the new plan.

2) Alex can enroll in a child-only QHP
   If Alex enrolls in a child-only QHP partway during the plan year, she will have to meet the entire deductible and out of pocket maximum as if she were enrolled in the QHP for the full 12 months. For example, if Alex was born on April 4th and coverage started with a child-only plan that had a $1,000 deductible, Alex must incur $1,000 in out of pocket expenses before December 31, 2014 in order for the insurer to begin covering the services.

3) Alex can be added to Jane and Jaime's existing QHP
   In this scenario, Alex's expenses would now factor into how the family meets their deductible. QHPs can have two different kinds of deductibles.

   Embedded Deductibles:
   In a plan with this type of deductible, Jane, Jaime and Alex will each have an individual deductible amount as well as a couple/family deductible amount. Once each individual meets their individual deductible, that individual starts paying co-pays or co-insurance

for services. Also, when the family meets the family deductible collectively, they all will pay copays or co-insurance for services. For example:

Jane and Jaime are enrolled in a QHP with a $2000 individual deductible and $4000 couple/family deductible. Jane has paid $2000 for her services out of pocket and now will pay the copay amount for services when she goes to see a provider. Jaime has only spent $1000 in out of pocket medical expenses for the year so Jaime will need to continue to pay out of pocket until the $2000 amount is met either by Jaime paying another $1,000 out of pocket for services or by both Jane and Jaime's out of pocket expenses reaching $4000.

Now Jane and Jaime add Alex to their plan. The deductible remains the same at $4000. (The deductible only changes when the policy changes from an individual policy to a couple policy, a parent/child policy, or a family policy, even if the individual stays in their QHP.) However, all three individuals must meet the $2000 deductible or the entire family must meet the $4000 deductible together before all of their services are subject to copays. So Jane has already paid the $2000 and is now paying copays. If Jaime has spent $1000 in services, and Alex has also had $1000 in services which means that now the whole family has satisfied their $4,000 family deductible and will only pay copays going forward.

Family Deductibles:
In a plan with this type of deductible, everyone's medical expenses go towards the deductible together and when they meet the couple/family deductible amount together, they have satisfied the deductible.

Jane and Jaime are enrolled in a QHP with a $2000 individual deductible and $4000 couple/family deductible. Jane has paid $2000 for her services out of pocket, but Jaime has only spent $1000 out of pocket, so the total they have spent towards their deductible is $3000. They will each continue to pay out of pocket for services until they both reach $4000 together.

Now they add Alex to their plan. Alex's expenses will also contribute to meeting the $4000 deductible and once their expenses totaled together equal $4000, they will start paying copays.

To find out if your deductible is an embedded or family deductible, you can contact your health plan, or find it in the "Design" description on the plan details page of the Marketplace web site.

4) Jane, Jaime and Alex enroll in a new QHP.
If all three family members enroll in a new QHP during the plan year, they all have to meet the new deductible amount and out of pocket limit as if they were enrolled in the

plan for the full 12 months. The $500 that Jane and Jaime already spent under their old plan would not carry over to the new plan.