



Enrollment

Frequently Asked Questions
FAQ #1 – April

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Transactions / Premium Payment / Enrollment

Q1: What happens when a cancellation occurs due to non-payment and the issuer receives the payment from the consumer after cancellation? Are issuers permitted to reinstate or will the enrollment need to come in again from FFE?

A1: Issuers may choose to cancel coverage of any qualified individual who does not make timely payment of the initial premium. If the individual submits payment after the cancellation has occurred, the issuer cannot reinstate the individual. If the qualified individual is still in an enrollment period at the time the coverage is cancelled, he or she may go through the plan selection process again and may select the same or another QHP, on or before the end of the enrollment period.

Q2: What information is passed to issuers if the customer does not sign up in the same session?

A2: If an individual does not make a selection of a QHP during a session on the Exchange, no information is provided to issuers.

Q3: Is there a list of definitions of all member and/or enrollment identifiers assigned through the enrollment cycle with the respective business rules / assumptions?

A3: Information on the identifiers used in the transaction is provided in the CMS Companion Guide, which is available on the CMS website at:
<http://cciio.cms.gov/resources/regulations/Files/companion-guide-for-ffe-enrollment-transaction-v1.5.pdf>.

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- Q4: Will issuers still send customers (consumers) premium invoices directly or will the Federal government collect premiums for individuals as well as SHOP business and send them to the health plan via the 820?**
- A4: In the first year of the FF-SHOP (2014), QHP issuers will be responsible for billing enrollees and employers to obtain required premium payments. The Federally-facilitated Exchange will not participate in the billing or collection of premiums. Beginning on or after January 1, 2015, the FF-SHOP will bill and collect premiums from the employer, and remit premiums to the appropriate issuers. The FF-SHOP will provide premium aggregation services to health plans via an electronic transaction, expected to be the ASC X12 Other Premium Payment 820 (Version 5010).
- Q5: Are issuers required to allow individuals to make partial payments on the first premium, where the member is redirected to the issuer site once enrollment has been completed? Are issuers required to allow partial payments on subsequent payments following first premium?**
- A5: Issuers may, but are not required to, allow individuals to make partial payments on the first month's premium. However, prior to the effective date of coverage, if the enrollee does not ultimately make full payment for their applicable portion of the first month's premium, the issuer must cancel coverage. An issuer may also accept partial payment for any subsequent month, but if the enrollee does not make full payment of their applicable portion of all premiums due before the end of the applicable grace period, the issuer must terminate coverage. An issuer is not required to collect any premium when the individual is redirected to the issuer website. However, if the issuer's website can accommodate making payment upon redirect, the enrollee may opt to do so at that time. If an individual is receiving APTC, he or she is only accountable for their portion of the premium for it to be considered a full payment. Therefore, if the individual has paid their share of the premium, the issuer may not wait until receiving the remainder from the federal government to maintain coverage.

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Q6: What are the requirements for how the (premium) payment is to be made (by check, credit card, etc.)?

A6: There are no regulatory requirements for how enrollees are to make their premium payments e.g. by paper, electronic or other means. However, in the April 2013 Letter to Issuers available on our website at:

http://www.cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf,

we state that QHP issuers should provide enrollees with information about how to make premium payments, and that they must be able to accept payment in ways that are not discriminatory.

Q7: What happens when the consumer is redirected to the issuer site to make the initial premium payment and then decides not to make that payment? Is the Exchange out of the process at that point and issuers would start their normal billing process?

A7: After an individual has made a plan selection, and is redirected to the issuer's website for instructions on how to make the first month's premium payment, there is no further role for the FFE. If an individual decides not to make the first month's premium payment on the website, the issuer may choose to bill the individual through their standard billing process.

Q8: What would the consumer experience be if the consumer returned to the FFE website in an attempt to pay the initial premium?

A8: If an enrollee returned to the FFE website in an attempt to pay the initial month's premium, s/he would be re-directed to the QHP issuer site for instructions on making the payment, as the Exchange does not accept or arrange any payment between the enrollees and issuers.

Q9: Will the consumer be provided a confirmation email with additional plan information, such as a link to the issuer's website, after plan selection?

A9: Once an individual makes a QHP selection, s/he will be redirected to that QHP's website where additional information about how to make the initial month's premium payment will be available.

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Q10: Will issuers be provided an enrollment start date and a subsequent termination date only when the record terminates (per request, non-payment or other)?

A10: When an individual enrolls with the QHP issuer, the enrollment transaction will include an enrollment effective date, but the initial transaction does not include a coverage end date. When an individual's coverage ends, the coverage termination date will be indicated in the 834 termination transaction. For the most current guidance on the enrollment transactions please refer to the CMS Companion Guide, available at:
<http://cciio.cms.gov/resources/regulations/Files/companion-guide-for-ffe-enrollment-transaction-v1.5.pdf>.

Q11: Will the same FFE identifier follow the member through the initial and any subsequent future enrollments?

A11: The member identifier will remain with an individual through the initial and subsequent enrollments as long as that individual remains in the same QHP. For example, an individual in an FFE selects a QHP issuer (issuer A). The individual is assigned an ID (1234) by the FFE. That ID will stay with the individual while he/she is enrolled with Issuer A. If the individual terminates with issuer A during annual open enrollment, and selects a different QHP issuer (issuer B) they will get a new ID (5678). Later, if for whatever reason, the individual terminates enrollment with issuer B and enrolls again with issuer A, he/she will be reassigned the same ID (1234) given during their first enrollment with issuer A.

Q12: Will HHS be providing additional scenarios that show the process flow if a customer exits the process before selecting a plan?

A12: To help issuers understand how the Federally-facilitated Market place will operate, CMS has prepared written scenarios which describe enrollment related events such as initial enrollments, terminations, changes, and cancellations. Each scenario includes a narrative of the event and specific information about data that will be included in the 834 enrollment transaction. The scenarios have been shared with issuers during training webinars and other meetings, and will be useful in their Requirements, Design, Development and Training activities. At this time, we are updating existing scenarios. If we identify an enrollment-related situation that has significant business, policy or transactional conditions, we will consider creating a scenario to share with the issuers. The example in this question will be considered accordingly.



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Q13: In the individual Exchange, what details or data elements are issuers required to show on the premium billing invoice?

A13: There are no regulatory requirements governing the content of an issuer's premium billing invoice for enrollees of the individual exchange

Q14: How do issuers communicate the inbound 834 rejects due to a failure on the issuers' side? How should issuers respond back to the Exchange to the inbound 834's with invalid email addresses?

A14: The Exchange will be using several transactions to address 834 (enrollment transaction rejections). One transaction is the TA1 for file level errors; another is the ASC X12 999 for functional group level errors (WEDI levels 1-6). A third transaction under consideration is the ASC X12 834 Application Advice for other errors (business logic edit failure). The process for communicating transaction errors using this third transaction (the X12 834) will likely require a separate companion guide for its use. Instructions for how issuers should communicate and respond to rejections will be provided soon.

If provided by the individual during the application process, the FFE will provide up to 3 communication contacts (home phone, work phone, cell phone, and email address) in the initial 834 enrollment transaction. If the issuer feels the email address provided by the enrollee is invalid, the issuer may obtain an updated email address from the enrollee, and should advise the enrollee to provide the FFE with the updated address by logging into "My Account" on the FFE website.