Special Enrollment Periods

This job aid provides information and guidance for Navigators, Certified Application Counselors (CACs), and Enrollment Assistance Personnel (EAPs) (collectively, assisters) on helping consumers apply for, enroll in, or change health coverage during a Special Enrollment Period (SEP).

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Version 2.0. April 2024. This information is intended only for the use of entities and individuals certified to serve as Navigators, certified application counselors, or non-Navigator assistance personnel in a Federally-facilitated Marketplace. The terms “Federally-facilitated Marketplace” and “FFM,” as used in this document, include FFMs where the state performs plan management functions. Some information in this manual may also be of interest to individuals helping consumers in State-based Marketplaces and State-based Marketplaces using the Federal Platform. This material was produced and disseminated at U.S. tax filer expense.

Overview

Special Enrollment Periods (SEPs) provide an opportunity for individuals who experience certain life changes, or qualifying life events, to enroll in or change their health coverage outside of the annual Open Enrollment (OE), as well as during OE for an earlier coverage start date. In addition, consumers can apply for and enroll in Medicaid or the Children's Health Insurance Program (CHIP) any time of the year, if eligible, whether they qualify for an SEP or not.

A qualifying life event can occur at any time during the year. Consumers who are enrolled in Marketplace coverage must report changes to eligibility information as soon as possible, generally within 30 days of the change. If consumers qualify for an SEP, they generally have 60 days from the date of their qualifying event to newly select or change their Marketplace coverage. When consumers report changes on a Marketplace application, the Marketplace re-determines consumers' eligibility and notifies them of:

- Any changes in eligibility for Marketplace coverage or help paying for coverage.
- Whether they are eligible for an SEP.
- Whether they are eligible for coverage through Medicaid or CHIP.
- When their coverage will start.
- Their next steps.

New Special Rule for Loss of Medicaid or CHIP Coverage

Beginning January 1, 2024, at the option of the Marketplace, a qualified individual or their dependent(s) whose loss of coverage is a loss of Medicaid or CHIP coverage will have 90 days after the triggering event to select a QHP. This aligns the SEP window following loss of Medicaid or CHIP with the 90-day Medicaid reconsideration window, which allows former beneficiaries to provide the necessary information to their state Medicaid agency to re-establish their eligibility for Medicaid or CHIP without having to complete a new application.

State-based Exchanges have the option to implement this change earlier than January 1, 2024, and to allow more than 90 days, if the State Medicaid agency permits or provides for a longer Medicaid or CHIP reconsideration period, for consumers to select a plan.

In the Marketplace, this will be implemented following the expiration of the Medicaid Unwinding SEP, which has been extended to November 30, 2024.

Qualifying Events

Consumers may visit the SEP screener and answer a few questions to find out if they may qualify for an SEP to enroll in or change plans. A consumer will need to complete a HealthCare.gov application in order to receive an official eligibility determination. Exhibit 1 lists the six SEP categories, provides a description of each category, and indicates how a consumer can access the SEP.

Exhibit 1 – SEP Qualifying Events

SEP Category	Description	Accessed Through
Loss of qualifying health coverage	A consumer (or anyone in their household) lost qualifying health coverage, also called minimum essential coverage (MEC). Some examples of qualifying coverage losses include: ▪ Coverage through a job or through another person's job. This also applies if consumers are now eligible for help paying for Marketplace coverage because their employer stops offering coverage or the coverage is no longer considered qualifying coverage. ▪ Most Medicaid or CHIP coverage (including pregnancy-related coverage and medically needy coverage). ▪ Medicare Part A (Hospital Insurance) or Medicare Advantage Plan (Part C) (but Medicare Part B (Medical Insurance) and Medicare drug coverage (Part D) by themselves don't count). ▪ Individual or group health plan coverage that is discontinued (no longer exists). ▪ Coverage under a parent's health plan (if they're on it). If a consumer turns 26 and loses coverage, they can qualify for this SEP. Note: Effective June 18, 2023, issuers participating in Exchanges on the Federal platform may not terminate coverage for dependent children who have reached age 26 (or the maximum age under State law) until the end of the plan year. Consumers may report a loss of qualifying health coverage up to 60 days before the loss of coverage. Note: A consumer is generally not eligible for this SEP if the consumer voluntarily dropped coverage, they lost the coverage more than 60 days ago, they didn't pay their premiums, or their coverage was taken away because of fraud or intentional misrepresentation. Consumers also are not eligible for this SEP if the coverage they lost did not qualify as minimum essential coverage. For example, if the consumer lost short-term limited duration insurance (STLDI), they would not qualify.	Marketplace application or Call Center

SEP Category	Description	Accessed Through
Change in Household Size	A consumer (or anyone in their household): ▪ Had a baby, adopted a child or placed a child for adoption, or placed a child for foster care. ▪ Gained or became a dependent due to a child support or other court order. ▪ Got married. Note: If they gained or became a dependent due to marriage, one spouse must have also had qualifying health coverage for one or more days in the 60 days prior to the marriage. This doesn't apply if the spouse: ▪ Was living in a foreign country or a U.S. territory for one or more days in the 60 days prior to the marriage. ▪ Is a member of a federally recognized tribe or an Alaska Native Claims Settlement (ANCSA) Corporation shareholder. ▪ Lived for one or more days during the 60 days before the marriage or during their most recent enrollment period in a service area where a qualified health plan was not available through the Marketplace. At the option of the Exchange, loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.	Marketplace application or Call Center

SEP Category	Description	Accessed Through
Change in Primary Place of Living	A consumer (or anyone in their household) had a change in their primary place of living and gains access to new Marketplace health plans. Household moves that qualify consumers for an SEP include: ▪ Moving to a new home in a new ZIP code or county. ▪ Moving to the U.S. from a foreign country or U.S. territory. ▪ Moving to or from the place they attend school. ▪ Moving to or from the place of their seasonal employment. ▪ Moving to or from a shelter or other transitional housing. Note: A consumer qualifies only if they had qualifying health coverage for one or more days in the 60 days prior to their move. This doesn't apply if: ▪ They were living in a foreign country or a U.S. territory for one or more days in the 60 days prior to the move. ▪ They're a member of a federally recognized tribe or an ANCSA Corporation shareholder. ▪ They lived for one or more days during the 60 days before their move or during their most recent enrollment period in a service area where a qualified health plan was not available through the Marketplace. Note: Moving only for medical treatment or staying somewhere for vacation doesn't qualify the consumer for an SEP.	Marketplace application or Call Center

SEP Category	Description	Accessed Through

Change in Eligibility for Marketplace Coverage or Help Paying for Coverage	A consumer (or anyone in their household):
	▪ Is enrolled in Marketplace coverage and reports a change that makes them:
	  ▪ Newly eligible for help paying for coverage (but not consumers who are determined newly eligible for a $0 maximum APTC), or
	  ▪ Newly ineligible for help paying for coverage (but not consumers who were previously eligible for a maximum APTC of $0 and are now ineligible for APTC), or
	  ▪ Eligible for a different amount cost-sharing reductions (CSRs).
	▪ At the option of the exchange, is not enrolled in Marketplace coverage and:
	  ▪ Experiences a decrease in household income; and
	  ▪ Is newly determined eligible for help paying for coverage (but not consumers who are determined newly eligible for a $0 maximum APTC); and
	  ▪ Had other MEC for at least one of the 60 days prior to their income change (such as a job-based plan or individual coverage they purchased outside of the Marketplace).
	▪ Becomes newly eligible for help paying for coverage because they moved to a different state and/or experienced a change in household income and they were previously both of these:
	  ▪ Ineligible for Medicaid coverage because they lived in a state that hasn't expanded Medicaid; and
	  ▪ Ineligible for help paying for coverage because their household income was below 100 percent of the federal poverty level (FPL).
	▪ Becomes newly eligible for Marketplace coverage because they've become a citizen, national, or lawfully present individual. Note: Changing from one legally present status to another does not qualify consumers for this SEP.
	▪ Becomes newly eligible for Marketplace coverage after being released from incarceration.
	▪ Gains or maintains status as a member of a federally recognized tribe or an ANCSA Corporation shareholder (a status that lets consumers change plans once per month, and lets their dependents enroll in or change plans with them).
	▪ Is an AmeriCorps service member starting or ending AmeriCorps service.
	▪ Has newly gained access to an Individual Coverage Health Reimbursement Arrangement (ICHRA) or is provided a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).
		Marketplace application or CMS caseworker via the Marketplace Call Center, depending on the qualifying event.

SEP Category	Description	Accessed Through

Enrollment or Plan Error	A consumer (or anyone in their household):
	▪ Wasn't enrolled in a plan or was enrolled in the wrong plan because of an error of the Exchange, including:
	  ▪ Misinformation, misrepresentation, misconduct, or inaction of someone working in an official capacity to help them enroll (like an insurance company, Navigator, certified application counselor, agent, or broker).
	  ▪ A technical error or other Marketplace-related enrollment delay.
	  ▪ A plan display error that resulted in wrong plan data (like plan benefit, service area, cost-sharing or premium information) displayed on HealthCare.gov at the time that they enrolled in the plan, if the Marketplace determines the error is adverse to consumers.
	Can adequately demonstrate that their Marketplace plan violated a material provision of its contract in relation to the enrollee.
		Experience an error of the Exchange: Marketplace Call Center
		
		Experience a plan contract violation or material error: CMS Caseworker

SEP Category	Description	Accessed Through
Other Qualifying Changes	A consumer (or anyone in their household): ▪ Experiences an exceptional circumstance, such as a serious medical condition, natural disaster, or other national or state-level emergency that kept them from enrolling.* ▪ Is a victim of domestic abuse or spousal abandonment and wants to enroll in a health plan separate from their abuser or abandoner; dependents on the same application may enroll in coverage at the same time as the victim. ▪ Applies for Marketplace coverage during Open Enrollment or because of an SEP qualifying event, is assessed as potentially eligible for Medicaid or CHIP, and then is determined Medicaid- or CHIP-ineligible after Open Enrollment ends or more than 60 days after the qualifying event; OR, applies for coverage at their State Medicaid or CHIP agency during OE, and the state agency later determines, outside of OE, that the consumer was not eligible. ▪ Does not receive timely notice of an SEP qualifying event and was otherwise reasonably unaware that the qualifying event occurred. ▪ At the option of the Exchange, submitted documents and resolved their DMI after the Marketplace and their coverage was ended. ▪ At the option of the Exchange, has annual household income at or below 100 percent of the federal poverty level (FPL), submitted documents to prove that they have an eligible immigration status, and didn't enroll in coverage while they waited for their documents to be reviewed. ▪ Is APTC-eligible, with a projected annual household income at or below 150 percent of the FPL. These consumers are eligible for a monthly SEP to enroll in or change from one QHP to another. In the 2025 Payment Notice, CMS made this SEP permanent. Previously, it was only available when these individuals were expected to contribute zero percent of their household income towards premiums. Beginning June 4, 2024, this SEP will be available to consumers with a projected household income at or below 150 percent of the FPL, without regard to the consumer's expected premium contribution. ▪ Has or had COBRA continuation coverage, and subsidies from a government entity end or employer contributions completely cease.	CMS Caseworker, Marketplace Call Center, or Marketplace application, depending on the qualifying event.

*CMS clarified in 2018 that consumers can qualify for an exceptional circumstances SEP if they missed their deadline to enroll in Exchange coverage during another SEP or to enroll during OE because they were impacted by a Federal Emergency Management Administration (FEMA)-declared national emergency or major disaster. Recent examples include the COVID-19 public health emergency, as well as wildfires, hurricanes, and flooding in certain areas. Consumers who miss their opportunity to enroll through an SEP or OE because they were impacted by a FEMA-declared emergency or disaster may call the Marketplace Call Center to enroll at 1-800-318-2596 (TTY: 1-855-889-4325). Eligible consumers may apply for an SEP under this policy from the end of their original enrollment window to up to 60 days after the end of the emergency or disaster. Their coverage will start on the first of the month after plan selection, but they have the option to request an effective date retroactive to when they would have had coverage if they had been able to select a plan during their original enrollment period and during the FEMA-designated incident period. For more information on FEMA designation information, visit the FEMA disaster information page, and refer to the 2023 guidance, Emergency and Major Disaster Declarations by the Federal Emergency Management Agency (FEMA) – Special Enrollment Periods (SEPs), Termination of Coverage, and Payment Deadline Flexibilities.

Prior Coverage Requirements

Some SEPs are available to anyone who's eligible for coverage and experienced a qualifying event.

Some SEPs are only for:

- Consumers who had qualifying health coverage for one or more days in the 60 days preceding their SEP qualifying event (e.g., marriage, change in primary place of living[i]). For examples of qualifying health coverage, see Qualifying Health Coverage in the HealthCare.gov glossary.

- Consumers who already have Marketplace coverage (e.g., an SEP for enrollees whose income changes, making them newly eligible or ineligible for help paying for coverage).

Prior coverage requirements do not apply to members of a federally recognized tribe or ANCSA Corporation shareholders.

The Marketplace will provide details and instructions on whether and how consumers need to prove prior coverage on their eligibility determination notice (EDN).

Coverage Effective Dates

When a consumer qualifies for an SEP, coverage starts based on the type of SEP.

- For many SEPs, coverage starts the first of the month after plan selection (for consumers who will lose coverage in the future, coverage starts the first of the month after their existing coverage ends and they pick a new plan).

- Other SEPs have an effective date of coverage retroactive to the date of the qualifying event. Consumers who do not want a retroactive effective date of coverage can call the Marketplace Call Center to request their coverage take effect on the first of the month following plan selection.

  Note: Beginning January 1, 2025, State Exchanges are required to align with the Marketplace SEP regular coverage effective date rules and provide coverage that's effective the first day of the month following plan selection if a consumer enrolls in a QHP during an SEP that has a regular coverage effective date. This change means that consumers in all Exchanges who select a plan after the 15th of the month will have coverage effective the first day of the next month.

Exhibit 2 describes coverage effective dates for certain common SEP categories and qualifying events.

Exhibit 2 – Coverage Effective Dates

SEP Category/Event	Coverage Effective Date
Loss of qualifying coverage	Plan selection after loss of MEC: First of the month after plan selection Plan selection prior to loss of MEC: First day of the month following the last day of prior MEC
Change in household size	Marriage: First of the month after plan selection Gaining or becoming a dependent due to birth, adoption, foster care placement, or court order: Retroactive to the date of the event Note: For birth, adoption, placement for adoption, placement in foster care, or court order, consumers 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.
Change in primary place of living	First of the month after plan selection
Change in eligibility for Marketplace coverage or help paying for coverage	First of the month after plan selection
Newly gaining access to an Individual Coverage HRA or to a QSEHRA	Plan selection prior to HRA start date: First of the month following HRA start date or on the HRA start date if the HRA starts on the first of a month Plan selection after HRA start date: First of the month after plan selection
Enrollment or plan error	Retroactive to the coverage effective date the consumer would have gotten absent the error, or the first of the month after plan selection, at the option of the consumer Note: There are some exceptions for certain types of errors.
Untimely notice of SEP qualifying event	Retroactive to the earliest coverage effective date that would have been available if they had received timely notice of the event

SEP Verification (SEPV)

When a consumer applies for coverage, they must attest that the information provided is true, including the facts that qualify them for the SEP. Consumers not currently enrolled in the Exchange applying for an SEP due to loss of qualifying health coverage are required to submit supporting documents to demonstrate SEP eligibility before they can start using their coverage.

This process of submitting supporting documents is called SEP verification, or SEPV. Consumers in Exchanges on the Federal platform are no longer required to submit supporting documents to confirm SEP eligibility for gaining or becoming a new dependent due to marriage, adoption, placement for adoption, placement in foster care, or through a child support order or other court order; permanent move; or Medicaid/CHIP denial.

Consumers not currently enrolled in the Exchange who apply for a loss of qualifying coverage SEP will generate an SEP verification issue (SVI). After the consumer submits their application, they'll learn if they have to provide any documentation to the Marketplace. Their EDN, which they can download or get in the mail, will provide details and instructions, including acceptable documents and deadlines for document submission. Documents must show that the consumer lost qualifying health coverage in the past 60 days or will lose coverage in the next 60 days. Consumers can and should pick a plan no later than 60 days after their loss of qualifying coverage, and the consumer has 30 days following plan selection to submit documents to resolve their SVI. Consumers must either upload their documents online or mail in copies of the documents (they shouldn't send originals) before they can make their first payment and start using their coverage. Uploading is fastest and easiest.

Note that consumers will not be enrolled in the plan they choose, and their plan selection will be pended (on hold) until the SVI is resolved.

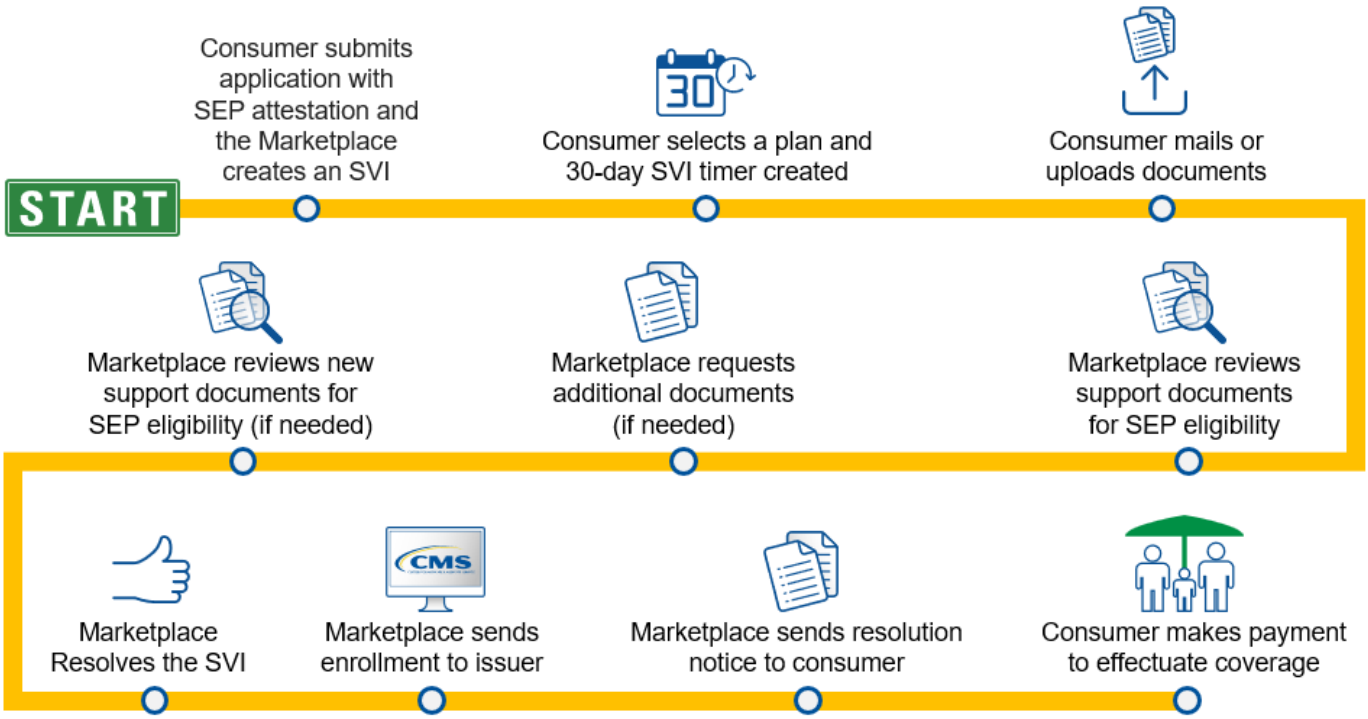
If the consumer's eligibility results don't indicate they need to provide documents, they don't have to. They can simply pick a plan and enroll.

Visit Send documents to confirm a Special Enrollment Period for a list of acceptable documents consumers can submit to verify their loss of qualifying coverage. For more information on submitting documents, visit Uploading Documents.

SVI Resolution Process

The process for resolving an SVI is illustrated in Exhibit 3.

Exhibit 3 – SVI Resolution Process



The Marketplace contacts consumers multiple times to explain their requirement to submit documents and remind them about how to do so, along with details about what documents to submit. Consumers can view and download most of these notices online in their HealthCare.gov account and will receive emails when these notices become available. Consumers who request to receive paper notices will get these notices by mail. Exhibit 4 describes notices the Marketplace may send during the SVI process based on consumer actions.

Exhibit 4 – SVI Resolution Process Notices

Action	Notice(s)
Consumers submit documents	▪ A **resolution notice** confirming that their SVI is resolved, or ▪ An **insufficient document notice** that explains why the Marketplace can't resolve an SVI with the submitted documents and that includes a request for acceptable documentation.
Consumers who don't submit documents or don't submit acceptable documentation by the indicated deadline	▪ An **expiration notice** explaining that their SVI wasn't resolved and that they won't be enrolled in coverage. ▪ A **final eligibility notice** with information about how to appeal if they disagree with this decision.
Consumers who don't pick a plan	▪ A **reminder notice** when they have at least 10 days left in the SEP window telling them that they must pick a plan and submit documents to begin using coverage.
Consumers complete their application	▪ An **EDN** that explains consumers' eligibility for health coverage, financial assistance, and an SEP. It will describe the requirement to resolve an SVI, including acceptable documents and deadlines for document submission. ▪ Note: If the consumer also has a DMI (sometimes referred to as an "inconsistency, application issue or follow up) and therefore must also submit other types of documents, their EDN will also include this information.
Consumers pick a plan	▪ A **pended plan selection (PPS) notice** that explains that the deadline to submit documents is 30 days after they picked a plan. It includes a list of next steps. It also provides the list of acceptable documents that consumers can submit to resolve the SVI. ▪ A **warning notice** when 20 days have passed after plan selection, for consumers who still need to submit documents.

If the Marketplace resolves a consumer's SVI, the consumer will be enrolled in coverage. Consumers' coverage effective date is based on their SEP type and when they pick a plan, but they can't use their coverage until their SEP eligibility is confirmed and they make their first premium payment. If a consumer's coverage effective date passes before their SVI is resolved, then their coverage effective date will be retroactive. Consumers will owe premiums for the retroactive period.

Consumers who have both a DMI and SVI will need to resolve their SVI before they can begin using coverage. In some cases, this may occur before the DMI is resolved. Consumers who resolve their SVI and/or only have a DMI pending resolution can start using coverage; however, they must still submit documents to keep their eligibility for Marketplace coverage and/or financial help.

For more information on resolving SVIs and DMIs, visit Special Enrollment Periods, SEP Verification, and Complex Case Scenarios.

Plan Category Limitations

Marketplace enrollees and their dependents (including newly added household members) who qualify for the most common SEP types, like loss of qualifying coverage, change in primary place of living, or change in household size, will only be able to pick a plan from their current plan category or must wait until the next OE to change to a plan in a different category for the next plan year. For example, someone who's already enrolled in a Bronze plan (and who qualifies for an SEP and wants to change plans) will only view and be able to choose from Bronze category plans.

There are some circumstances that will allow a consumer to change to a different plan category:

- Marketplace enrollees who become newly eligible for cost-sharing reductions (CSRs) and who aren't already enrolled in a Silver plan can change to a Silver plan so they can use their CSRs.
- Marketplace enrollees who become newly ineligible for CSRs and are enrolled in a Silver plan can change to a gold or bronze plan.
- Marketplace enrollees who do not qualify for an SEP but who gain SEP-eligible dependents due to marriage, birth, adoption, foster care, or court order can enroll the new dependent in the existing enrollee's current plan and generally can't change plans at all. However, if a plan's business rules prevent an existing enrollee from adding a newly enrolling household member to their plan, the family can enroll together in a different plan in the same category. If no other plans are available in this category, the family can enroll together in a plan with a category that's one level up or one level down. Alternately, existing enrollees can place the newly added dependent in the dependent's own enrollment group and in any plan in any category for the remainder of the year.
- Gaining access to an Individual Coverage HRA or a QSEHRA.
- SEPs for complex situations, like those due to misrepresentation or plan display error, gaining or maintaining status as a member of a federally recognized tribe or an ANSCA Corporation shareholder, or other rare situations, don't limit consumers' ability to choose a new plan during an SEP window, if they want a different one.

Consumers newly enrolling in Marketplace coverage aren't limited in the plans they can choose to enroll in. However, these consumers may have to submit documents to confirm information about their eligibility for an SEP.

For more information on Marketplace plan categories, visit How to pick a health insurance plan. For more information on plan category limitations, visit Changing plans — what you need to know.

SEP Eligibility Appeals

If a consumer's request for an SEP is denied, they can file an appeal. If the denial is overturned, they can get coverage back to the date their SEP was denied. To file an appeal, consumers should either:

- Locate their state's appeal form at How to appeal a Marketplace decision, download it, and fill it out; or
- Mail their appeal to:
  Health Insurance Marketplace®[ii]
  Attn: Appeals
  465 Industrial Blvd
  London, KY 40750-0062

When possible, the consumer should include a copy of any EDN or other official notice they received.

Additional Resources

- SEP Screener (Spanish)
- Special Enrollment Period Overview and Complex Case Scenarios
- Understanding Special Enrollment Periods
- HealthCare.gov: Getting Coverage Outside Open Enrollment
- Report Life Changes When You Have Marketplace Coverage

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[i] Unless they moved to the U.S. from a foreign country or U.S. territory, are a member of a federally recognized tribe or are an ANCSA Corporation shareholder, or lived for one or more days during the 60 days before their qualifying event or during their most recent enrollment period in a service area where no qualified health plan (QHP) was available through the Marketplace.

[ii] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.