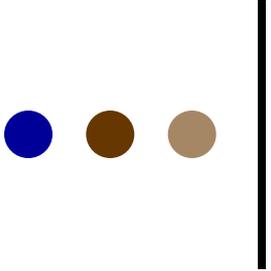


Coordinating HBE, Medicaid, and IRS Regulations*

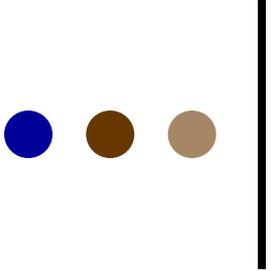
Presentation by: Pam Silberman, JD, DrPH

* Note: Information taken from: *Overview and Analysis of Proposed Exchange, Medicaid and IRS Regulations Issued on August 12, 2011*. State Health Reform Assistance Network. Issue Brief. Sept. 2011. Prepared by Manatt Health Solutions, and from applicable proposed federal regulations.



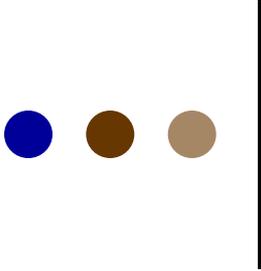
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- Notice of Proposed Rulemaking
- Overview
- Eligibility Criteria and Verification
- Enrollment
- Redetermination
- Enhanced FMAP for Newly Medicaid Eligibles
- SHOP Participation
- Premium Tax Credit and Reconciliation



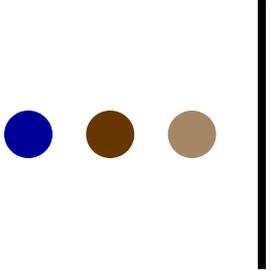
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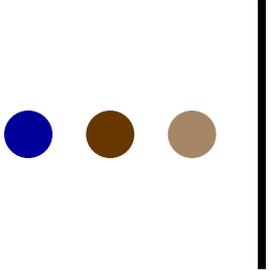
Notices of Proposed Rulemaking

- Proposed regulations governing HBE functions in the individual market, eligibility determinations, and HBE standards for employers.
 - 76 Fed. Register 51202-51237 (August 17, 2011)
 - Comments due no later than October 31, 2011.
- Proposed regulations governing Medicaid eligibility changes under the Affordable Care Act.
 - 76 Fed. Register 51147-51199 (August 17, 2011)
 - Comments due no later than October 31, 2011.
- Proposed regulations governing the Health Insurance Premium Tax Credit.
 - 76 Fed. Register 50931-50949 (August 17, 2011)
 - Comments due no later than October 31, 2011. Public hearing scheduled for Nov. 17, 2011.



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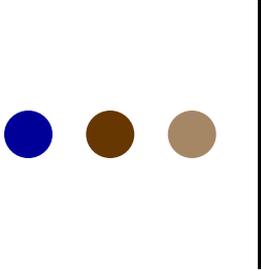


Overview

- The three sets of proposed regulations outline the procedures for:
 - Enrollment in unsubsidized coverage in the HBE.
 - Eligibility verification for any of the insurance affordability programs, including:
 - Advance payment of the premium tax credit, and cost sharing subsidies.
 - Medicaid, CHIP or the Basic Health Program (if applicable).
- The regulations attempt to balance administrative simplicity and ease of enrollment with the need to ensure program integrity.

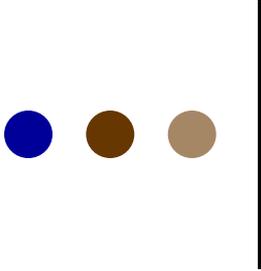
Overview (cont'd)

- Eligibility for all insurance affordability programs based on MAGI-income standards.
 - There are some differences in how income is calculated among different insurance affordability programs (described later).
- Eligibility for Medicaid based on MAGI-income standards determined first.
 - Next, determine eligibility for other insurance affordability programs that are based on being ineligible for Medicaid (ie, Children's Health Insurance Program (CHIP) or Basic Health Plan (BHP)).
 - Finally, determine eligibility for the advance premium tax credit. People must be ineligible for Medicaid, CHIP, BHP, or other minimum essential coverage before being determined eligible for the advance premium tax credit and cost sharing subsidies.



Coordination between HBE and Medicaid/CHIP Agencies

- HBE, Medicaid, CHIP, and BHP(if applicable) must coordinate eligibility process.
 - Mandatory data sharing across agencies, with confidentiality and security protections.
- Coordination *options* to ease eligibility and enrollment across insurance affordability programs:
 - Medicaid/CHIP *may* delegate the selection of health plans or providers (for primary care case management programs) to the HBE.
 - HBE *may* delegate to Medicaid eligibility for QHP or advance payment of premium tax credits and cost sharing reductions.
 - Medicaid *may* delegate to HBE eligibility determination for non-MAGI populations (eg, Medicaid for long-term care).



Agreement between Medicaid, CHIP, and HBE

- States must enter into agreements between Medicaid, CHIP, and HBE agencies to ensure seamless eligibility and enrollment (42 CFR 435.1200). Three options:
 - Medicaid, CHIP, and HBE can enter into an agreement to allow one of the agencies to perform all or some of the eligibility/enrollment/redetermination functions.
 - A state could develop a fully integrated system where the responsibilities of all entities are performed by a single integrated entity. (*Note: may be limited to public entities**).
 - Each entity could fulfill its own functions, but seamlessly exchange information and data.
 - Note: the “single state Medicaid agency” is still responsible for ensuring that eligibility determinations made consistently with Medicaid laws.

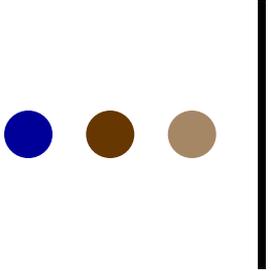
Coordination in Eligibility

Determination (45 CFR 155.345, 42 CFR 435.1200)

- HBE must determine eligibility to enroll in a QHP for individuals who are not seeking financial assistance (ie, no insurance affordability program).
- HBE, Medicaid, CHIP, and Basic Health Plan (BHP) must coordinate eligibility and enrollment.
 - Parallel obligations on all agencies to determine eligibility for other programs.
 - Generally, agencies may not ask for information beyond what is necessary to determine eligibility for insurance affordability programs.

Common Application

- States must use a single, streamlined application for all insurance affordability programs. The application will be developed by the Secretary. (42 CFR 435.907; 45 CFR 155.310(a))
 - States can use alternative applications if approved by the Secretary.
 - States can use supplemental forms to obtain other information for people who are not eligible on the basis of MAGI.
- Individuals must be able to apply by internet, telephone, mail, in person, or fax (for Medicaid).



Agenda

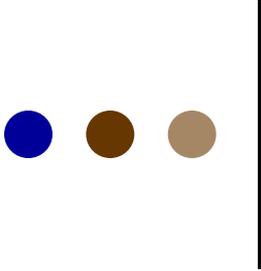
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Eligibility to Enroll in QHP without Financial Assistance

- To enroll in the QHP without financial assistance through an insurance affordability program, a person must be:
 - A citizen or immigrant who is lawfully present;
 - Not incarcerated; and
 - Residing within the HBE service area.
- Individuals who meet these requirements and do not want a premium tax credit or cost sharing subsidies can enroll in a QHP without any further verification. (45 CFR 155.305(a))

Eligibility to Enroll in Insurance Affordability Programs

- Eligibility for enrollment in an insurance affordability program. (45 CFR 155.305, 42 CFR 435.603, 457.300 et. seq.)
 - If requested, the HBE must determine eligibility for insurance affordability programs.
 - Must begin by determining eligibility for Medicaid, CHIP, or BHP.
 - Determine if the person is enrolled in, or eligible for minimum essential coverage through an employer. (45 CFR 155.320(b)(d)(e)).
 - If not eligible for minimum essential coverage through governmental programs or employer, then determine eligibility for advance payment of premium tax credit.



Minimum Essential

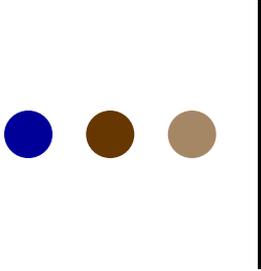
Coverage (26 CFR 1.36B-2(c))

○ Government-sponsored health plans

- Individuals eligible for government-sponsored health plans are considered to have essential minimum coverage, regardless of whether they are enrolled.
- Individuals eligible for government programs are generally considered eligible the first day of the first full month in which the individual may receive benefits.
 - Special rules if coverage is retroactive to prior month or if person fails to apply reasonably promptly after the event that establishes eligibility.
- An individual is not treated as eligible for Medicaid, CHIP, or similar program if the Exchange determines that the individual is not eligible for the program when the person enrolled in the QHP.

Advance Payment of Premium Tax Credits (45 CFR 155.305, IRS 1.36B-2(b)(c))

- Individuals are eligible for premium tax credits if:
 - 1) They are the “primary taxpayer” with incomes between 100-400% FPL.*
 - Primary taxpayer is one who is not claimed as a dependent by another taxpayer. If married, the primary taxpayer must file jointly to qualify for the premium tax credit and cost sharing subsidies.
 - 2) At least one person in the tax filing unit is eligible to enroll in the QHP.
 - A person who is not lawfully present or who is incarcerated may still be a primary taxpayer if another dependent is eligible to enroll.
 - 3) They do not qualify for minimum essential coverage through an employer sponsored plan or governmental program.
 - *Note: An individual can elect to receive less than the full advance payment.* (45 CFR 155.305(d)(2)(i))



Eligibility for Premium Tax Credit (26 CFR 1.36B-2)

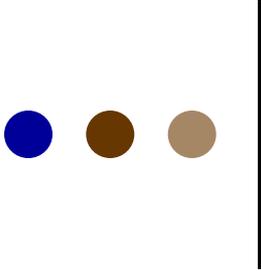
- Other eligibility requirements:
 - If a taxpayer is married, the couple must file jointly in order to qualify for the tax credit.
 - Individuals are not applicable taxpayers if someone else can claim them as dependents under their return.
 - Individuals who are not lawfully present or who are incarcerated may not be covered by a qualified health plan through the HBE. (However, the individual may be a qualified taxpayer if other family members are eligible to enroll in the plan).

Premium Tax Credit and Cost Sharing Subsidies

Individual or family income	Maximum premiums (Percent of family income)	Out-of-pocket cost sharing* (Amount family pays out-of-pocket)	Out-of-pocket cost sharing limits (Examples below based on 2012 HSA OOP limits)**
<133% FPL	2% of income	6%	\$2,017 (ind)/\$4,033 (fam) (1/3 rd HSA limit)
133-150% FPL	3-4%	6%	\$2,017 / \$4,033
150-200% FPL	4-6.3%	13%	\$2,017/ \$4,033
200-250% FPL	6.3-8.05%	27%	\$3,025/ \$6,050 (1/2 HSA limit)
250-300% FPL	8.05-9.5%	30%	\$3,025/ \$6,050
300-400% FPL	9.5%	30%	\$4,033/ \$8,067 (2/3 ^{rds} HSA limit)

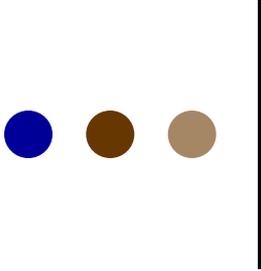
*Out-of-pocket cost sharing includes deductibles, coinsurance, copays.

**Out of pocket limits do not include premium costs. Annual cost sharing limited to: \$6,050 per individual and \$12,100 family in 2012 (HSA limits) (Sec. 1302(c), 1401, 1402, as amended by Sec. 1001 of Reconciliation)



General Eligibility Requirements

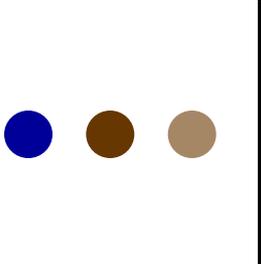
- All insurance affordability programs must obtain information about:
 - Citizenship or immigration status, household size and composition, residency, income (using MAGI rules).
 - In general, the verification requirements are very similar across insurance affordability programs, however:
 - Some differences in how to count income between Medicaid and HBE (for premium tax credit).
 - Slightly different rules for household composition.
 - Medicaid has specific verification requirements for pregnancy. HBE has specific rules to verify that the person is not incarcerated.



Eligibility Verification (45 CFR

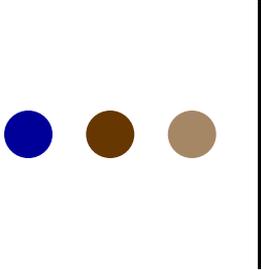
155.315, 155.320, 42 CFR 435.945, 435.948, 435.952)

- Medicaid, CHIP, and Exchange will use electronic data and applicant's attestation to verify eligibility.
 - Data sources include Social Security Administration (SSA), Dept. of Homeland Security (DHS), Internal Revenue Services (IRS), and state data sources (to verify income).
 - May not ask applicant for documentation of information that can be obtained electronically.
 - Should rely on the individual's attestation if the information the applicant provides is reasonably compatible with electronic data or information from other sources.
 - Reasonably compatible means generally consistent. It does not mean identical, but the federal government leaves it to the states to operationalize. (42 CFR 435.952(c); 45 CFR 155.315, 320).



Electronic Data Matches (45 CFR 155.315, 42 CFR 435.948, 435.949)

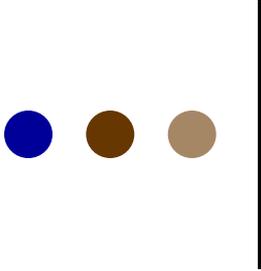
- Federal hub: The US DHHS will serve as the federal hub for electronic verification of eligibility criteria needed for insurance affordability programs.
 - Will include access to SSA (for citizenship and wages), Department of Homeland Security (immigration status), and Department of Treasury (tax returns).
- State data sources. States must establish electronic interchanges with other state databases to verify current income and other non-financial eligibility criteria.
 - May include: data matches with State Wage Information Collection Agency (SWICA) or Employment Security Commission, and information related to eligibility or enrollment in public assistance, SNAP, and other insurance affordability program.



Income Eligibility

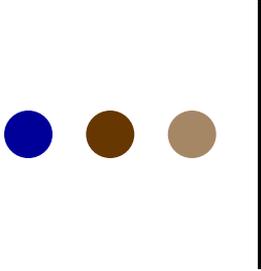
(45 CFR 155.305(c)(f), 42 CFR 435.603, IRS 1.36B-2(b)(1))

- Insurance affordability programs use IRS Modified Adjusted Gross Income (MAGI) rules to determine income eligibility:
 - Three Medicaid exceptions to IRS (MAGI) income rules: Lump sum payments counted in month received; educational scholarships or fellowships excluded from income; and certain types of income for American Indians or Alaskan Natives excluded.
- MAGI income determinations based on:
 - Current income for Medicaid (or at state option, can take into account future changes that can be reasonably anticipated).
 - Annualized income for premium tax credits.
 - *Note: HBE must first look at current income to determine Medicaid eligibility, and if not eligible, base determination for premium tax credit on estimated annual income.*



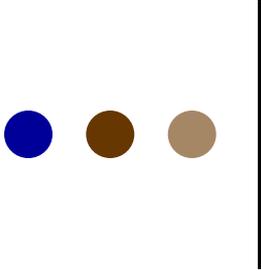
Use of MAGI to Determine Income Eligibility (42 CFR 435.603(i))

- MAGI rules do not apply to certain Medicaid groups, including:
 - Individuals who receive Medicaid because of other cash assistance (eg, SSI or those determined eligible because of “Express Lane” eligibility).
 - Aged, blind or disabled populations.
 - Individuals seeking assistance because of a need for long-term care (home and community or institutional).
 - Individuals eligible for a Medicare cost sharing program.
 - People who are seeking coverage through the Medically Needy program.



Income Verification (45 CFR 155.320; 42 CFR 435.935, 435.948)

- The HBE must compute annual household income by first obtaining tax data from the IRS.
 - The HBE must send this information to the applicant to validate to determine if income represents an accurate projection of the family's household income for the benefit year. If its not reasonably accurate, the HBE must ask the applicant to attest to projected annual income. (45 CFR 155.320(c)(3)).
 - If the applicant states his/her income is likely to increase, accept the applicants self-attestation.
 - Special rules if the applicant's income has decreased at least 20%, is filing an application for unemployment benefits, or is not required to file a tax return.



Income Verification (45 CFR 155.320; 42 CFR 435.935, 435.948)

- Medicaid must accept the applicants attestation to current income unless it is not reasonably compatible with other information.
 - The state agency (or HBE) must also seek verification of current income through state and federal agencies, state databases related to wages or other income, and electronic data about other public assistance, SNAP or insurance affordability programs.

Citizenship and

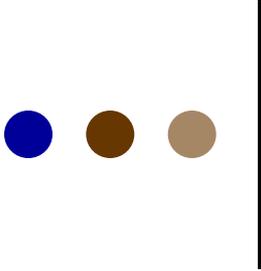
Immigration (45 CFR 155.305, 155.315, 42 CFR 435.945)

- HBE must follow Medicaid rules with respect to definition of lawfully present immigrants.
 - Medicaid excludes immigrants from coverage for the first five years in which they are lawfully present.
 - CHIP allows states to cover pregnant women and children in the first five years.
 - HBE must provide coverage to lawfully present immigrants without any time delay if they otherwise meet eligibility requirements.
- Verification: Citizenship must be verified through Social Security Administration (with SSN), immigration through DHS.

Family and Household

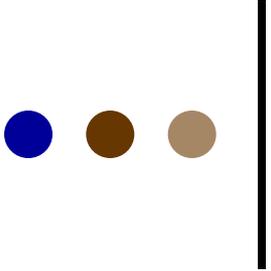
Definition (42 CFR 435.603(b)(f), 26 CFR 1.36B-1(d)-(e))

- In general, a family includes those individuals for whom the primary taxpayer claimed a personal exemption.
- Special Medicaid rules:
 - Non custodial parents: Medicaid counts the child in the family where the child resides.
 - Children living with caretaker relatives (such as grandparents): Medicaid eligibility based on child's income only (not caretaker relatives who have no legal responsibility to support the child).
 - Pregnant women: Medicaid counts pregnant women as two people.
 - Families who do not file taxes: Medicaid defines the household as the applicant, spouse, and any children or step-children living with the applicant.



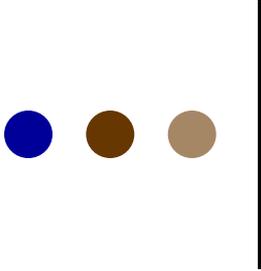
Residency (45 CFR 155.305, 155.315; 42 CFR 435.403, 435.956)

- Residency for Medicaid and HBE determined by where the individual is living and has “intent to reside.”
 - HBE must accept applicant’s attestation.
 - State may (or may not) accept attestation for Medicaid eligibility purposes. If seek additional verification through electronic data source, the HBE must follow the same rules for determining eligibility for insurance affordability rules.



Pregnancy (42 CFR 435.956)

- State agency must accept the person's attestation about pregnancy status for Medicaid eligibility.
 - The regulations silent on verification of pregnancy for HBE purposes.
- Differences in how pregnant women counted in different insurance affordability programs.
 - Counted as two people for Medicaid.
 - Counted as one person for advance payment of premium tax credit and cost sharing subsidy.

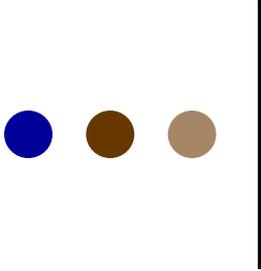


Incarceration (45 CFR 155.315)

- The HBE must verify that the individual is not incarcerated through electronic data sources.
 - Medicaid is silent on this.

Eligibility for Employer-Sponsored Plan (45 CFR 155.320(d)(e))

- The individual must attest, and the HBE verify, whether a person is eligible for minimum essential coverage through an employer sponsored plan.
 - Applicants must provide the name, address and employer identification number of employer; whether the employee is full time; whether the employer offers insurance coverage; and if the employer offers coverage, the lowest cost option for the applicant (and the applicant's contribution).
 - HBE required to verify this information against other information provided by employer.
 - HHS is seeking comments on how to make it easier for employers and employees to meet this requirement.



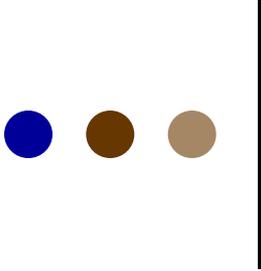
Minimum Essential Coverage (26 CFR 1.36B-2(c))

- Special rules for employer-sponsored minimum essential coverage (26 CFR 1.36B-2(c)(3)):
 - Individuals who *may enroll* in eligible employer sponsored plan and those who may enroll because of a relationship to the employee (spouse, child) are eligible for minimum essential coverage *if* the plan is affordable *and* provides minimum value (based on the affordability to the employee for self-only coverage).
 - Individuals and their family members are considered to have access to employer-sponsored coverage if they could have enrolled during annual or special enrollment periods, even if they chose not to enroll.
 - However, different rules apply to people eligible for continuation coverage. In that event, an individual is considered to be covered by minimum essential employer-sponsored coverage only if he/she enrolls in the continuation coverage.

Minimum Essential

Coverage (26 CFR 1.36B-2(c))

- Employer-sponsored minimum essential coverage (26 CFR 1.36B-2(c)(3)):
 - *Affordability*: “...An eligible employer-sponsored plan is affordable for an employee or a related individual if the portion of the annual premium the employee must pay, whether by salary reduction or otherwise ... for self-only coverage for the taxable year does not exceed the required contribution percentage [9.5%] of the applicable taxpayer’s household income for the taxable year.” (26 CFR 1.36B-2(c)(3)(v)(A))
 - *Note: IRS noted that different rules will apply to determine whether the family is exempt from the individual mandate. If the cost of family coverage exceeds 8% of the family’s household income, then they are not required to have coverage.* (IRS Preamble 1(b)(ii)(B))



Minimum Essential Coverage (26 CFR 1.36B-2(c))

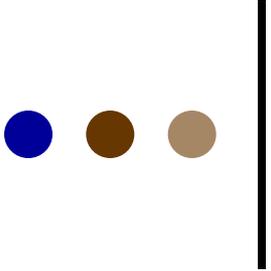
- Employer-sponsored minimum essential coverage (26 CFR 1.36B-2(c)(3)):
 - *Affordability* (cont'd):
 - If the individual obtains coverage through the HBE and does not seek an advanced determination of affordability of employer-sponsored insurance, then eligibility will be determined later based on actual income and costs of self-only coverage through the employer.
 - *Minimum value*: An eligible employer-sponsored plan provides minimum value if the plan's share of total allowed costs of the covered benefits is at least 60%. (26 CFR 1.36B-2(c)(3)(vi)):
 - *Note: Grandfathered plans and large employer plans are not required to provide the essential benefits.*

● ● ● | Safe Harbor for Employers

- The ACA requires large employers (50+ FTE employees) to offer affordable minimum essential coverage to their employees or pay a penalty.
 - Affordability based on the premium for self-only coverage not exceeding 9.5% of an employee's household income.
 - This is difficult for employers, as employers know their employees' wages—but not total household income.
 - IRS noted that future rulemaking is expected to provide a *safe harbor* for employers if the employee portion of the self-only coverage for the lowest cost plan does not exceed 9.5% of the employee's wages.

Verification if Conflicting Information or Inability to Verify Electronically

- Special rules:
 - HBE: If the HBE receives inconsistent information or cannot verify the information, the applicant must be able to enroll in the HBE, with applicable tax credits, and be given 90 days to verify the outstanding question. (45 CFR 155.315(e))
 - Medicaid: if the Medicaid agency receives inconsistent information or cannot verify information, the agency must give the applicant “reasonable time” to resolve the discrepancy. (42 CFR 435.952)



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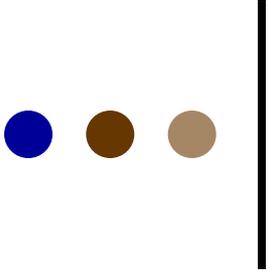
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Enrollment: Advance

Payment of Premium Tax

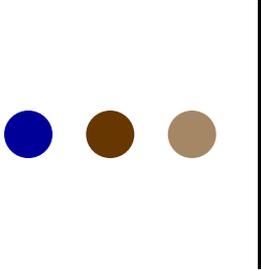
Credit (45 CFR 155.340, 310)

- If the HBE determines the applicant is eligible for advance payments of premium tax credit or cost sharing reductions, or eligibility has changed, the HBE must:
 - Send notice to the applicant.
 - Send information to the US DHHS so that HHS can begin, end, or change the advance payment of premium tax credits or cost sharing reductions.
 - Send information to the QHP, so that the QHP can modify the individual's premiums or cost-sharing (as applicable).
 - Send information to the employer, if the HBE determines that the employer does not provide affordable minimum essential coverage.



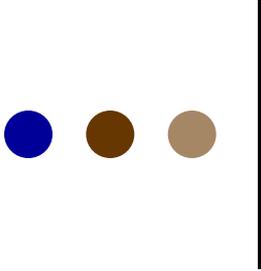
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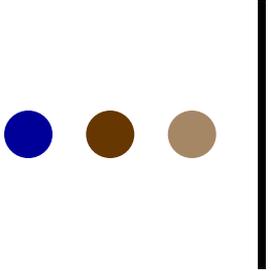
Redeterminations for Changes (45 CFR 155.330)

- Individuals must report changes that could impact on eligibility for advanced payment of premium tax credits within 30 days.
 - HBE also has independent responsibility to periodically examine electronic data sources to determine if person died, or began receiving Medicaid, CHIP, or BHP.
- Medicaid has similar reporting requirements for changes.



Annual Redeterminations (45 CFR 155.335, 42 CFR 435.916)

- HBE must redetermine eligibility of QHP enrollees on an annual basis, and must obtain tax return data for those receiving advance payment of tax credits.
 - HBE will send individuals a notice with projected income for upcoming year, amount of premium tax credits and cost sharing subsidy. Individual must review notice, sign if accurate, or provide new information within 30 days.
 - If the HBE does not receive new information, it will make a determination based on information provided in notice.
 - HBE will not make a new premium tax credit eligibility determination if the family failed to file taxes in the preceeding year.
- Medicaid and CHIP eligibility will also be redetermined on yearly basis, using similar process.

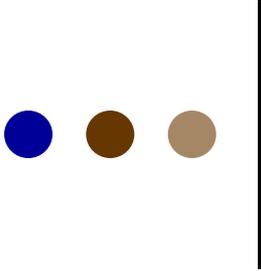


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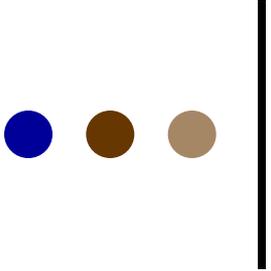
Federal Medical Assistance Percentage (FMAP) (433.10; 433.204)

- Federal government will pay 100% of costs of *newly eligibles* in first three fiscal years (2014-2016)* (Sec. 2001(3), amended Sec. 1201 Reconciliation)
 - After first three years, federal government will pay 95% (2017), 94% (2018) , 93% (2019) and 90% (2020 and thereafter).
- States receive regular FMAP for people who would have been eligible (“*existing eligibles*”) using eligibility rules in effect in Dec. 2009.
 - Current FMAP rate in North Carolina is 64.71 (FFY 2011).
- States must submit annual report on the number of individuals enrolled and newly enrolled in Medicaid.



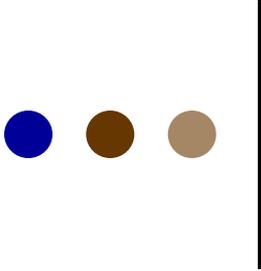
Methodology to Determine New Eligibles (42 CFR 433.206)

- States have a choice of methodology to determine which individuals are newly eligible vs. existing eligibles:
 - Apply state specific eligibility thresholds and proxies. (42 CFR 433.208)
 - Conducting statistically valid sample. (42 CFR 433.210)
 - Using CMS established FMAP proportion rate. (42 CFR 433.212)
- States must notify CMS no later than Dec. 31, 2012 (initially), or at least 2 years prior to the year in which the state will implement the method.
 - States must use the methodology for at least 3 consecutive years before changing to another method.



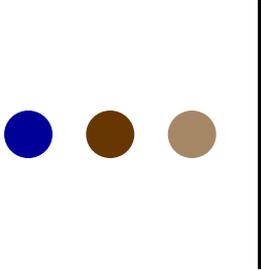
Agenda

- Notice of Proposed Rulemaking
- Overview
- Eligibility Criteria and Verification
- Enrollment
- Redetermination
- Enhanced FMAP for Newly Medicaid Eligibles
- **SHOP Participation**
- Premium Tax Credit and Reconciliation



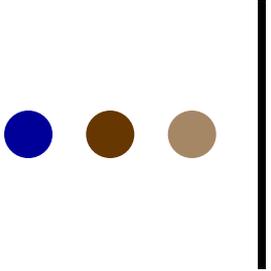
Employer Interaction and Participation in SHOP (45 CFR 157.200)

- Only qualified small employers may participate in the SHOP (as defined in 45 CFR 155.710).
 - Qualified small employer must:
 - Meet size requirements (ie, have at least one but not more than 50 (or 100) employees).
 - Offer coverage, at a minimum, to all full-time employees.
 - Have principal business address in SHOP service area or offer coverage through the SHOP serving that employee's primary worksite.
 - A qualified employer may continue to participate in the SHOP even if it ceases to be a small employer.
 - A qualified employer may participate in multiple SHOPS.



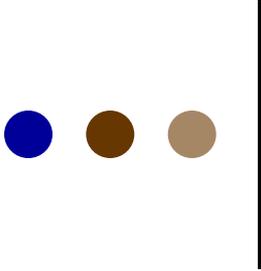
Employer Requirements in SHOP (45 CFR 157.200)

- To participate in the SHOP, the employer must:
 - Make coverage available to employees during open enrollment periods (pursuant to: 45 CFR 155.705)
 - Submit any premium contributions (pursuant to 45 CFR 155.705)
 - Provide employees hired outside the initial or annual enrollment period to seek coverage beginning the first day of employment (45 CFR 155.725)
 - Provide the SHOP with information about changes in employee eligibility status
 - Adhere to the annual employer election period (45 CFR 155.725(c))
 - If the employer doesn't elect new coverage during the open enrollment period, the employer will continue to offer the same plan, at the same coverage level, during the next year.



Agenda

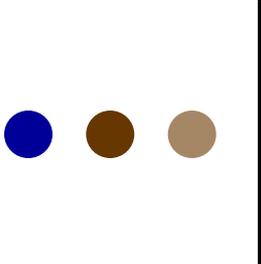
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Computing the Premium Assistance Credit Amount

(26 CFR 1.36B-3)

- Taxpayer's premium assistance credit for a taxable year is the sum of the premium assistance amounts for all coverage months for the individual in the taxpayer's family.
- Premium assistance amount for a coverage month is the *lesser* of:
 - Premiums for the month for one or more qualified health plans in which a taxpayer or a member of the taxpayer's family enrolls, *or*
 - The excess of the adjusted monthly premium for the applicable benchmark plan over $1/12^{\text{th}}$ of the product of a taxpayer's household income and the applicable percentage for the taxable year.



Calculating the Premium

Assistance Amount (26 CFR 1.36B-3)

- *Adjusted Monthly Premium:* Premium an insurer would charge for the applicable benchmark plan to cover all members of the taxpayer's coverage family, adjusted only for the age of each family member. (26 CFR 1.36B-3(e))
- *Applicable Benchmark Plan:* The **second lowest cost silver plan** for self-only or family coverage that is offered at the time a taxpayer or family member enrolls in a qualified health plan in the HBE. The applicable benchmark plan is for the rating area where the taxpayer resides. (26 CFR 1.36B-3(f))
 - If the HBE offers categories of family coverage (eg, two adults, one adult with children, two adults with children), then benchmark for family coverage is based on the coverage category that applies to the taxpayer's coverage family.

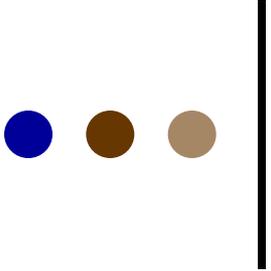
Applicable Percentage Table

(26 CFR 1.36B-3(g)(2))

Household income percentage of federal poverty levels*	Initial Percentage	Final Percentage
Less than 133%	2.0	2.0
At least 133% but less than 150%	3.0	4.0
At least 150%, but less than 200%	4.0	6.3
At least 200%, but less than 250%	6.3	8.05
At least 250%, but less than 300%	8.05	9.5
At least 300%, but less than 400%	9.5	9.5

To determine the amount of the premium tax credit:

- 1) Determine taxpayers required contribution (multiply the household's income by the applicable percentage).
- 2) Subtract the taxpayer's required contribution from second-lowest cost silver benchmark plan. The difference, if any, is the premium tax credit.



Example

- The Smiths family have a modified adjusted gross income of \$46,935/year (210% FPG)
 - They must pay 6.65% of their family income in premiums for the second lowest cost silver plan.*
 - Assume the second lowest cost silver plan for family coverage is \$13,700/year.
 - The Smith's share of the second lowest cost silver plan would be: \$3,121/year. ($6.65\% \times \$46,935$). They would be eligible for a premium tax credit of: \$10,579/year.
 - If the Smiths choose a higher cost plan, they would be responsible for anything above \$10,579/year.

The Smiths household income is 210% of the FPG, which is 10 percentage points over the initial household range (200% FPG). The difference between the lower and upper limits of the income range is 50 points (250-200%). $10/50=20\%$. The difference between the initial premium percentage (6.3) and the second premium percentage (8.05)=1.75. $20\% \text{ of } 1.75 = .35$. Adding this to the lowest premium percentage = 6.65.

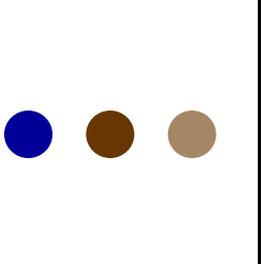
● ● ● | **Reconciliation** (26 CFR 1.36B-4)

- At the end of the year, the taxpayer's advance premium tax credit will be reconciled with what the taxpayer should have received (using actual household income and family size for the taxable year).
 - If the advance premium tax credit was less than the actual premium tax credit, the individual will receive an additional refund.
 - If the advance premium tax credit was greater than the actual tax credit, the individual will owe the excess as an additional tax liability.

Reconciliation (26 CFR 1.36B-4)

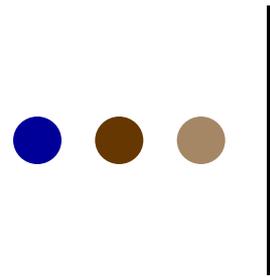
Household income as percentage of federal poverty lines*	Repayment amount maximum for individuals	Repayment amount maximum for families
Less than 200%	\$300	\$600
At least 200% but less than 300%	\$750	\$1,500
At least 300%, but less than 400%	\$1,250	\$2,500
400% or more	No limits on repayment amounts	No limits on repayment amounts

* As an example, the 2011 Federal Poverty Levels are: \$10,890/yr. (individual); \$14,710 (family of 2); \$18,530 (family of three); \$22,350 (family of four).



HBE Reporting (26 CFR 1.36B-5)

- HBE's must report information to the IRS and taxpayers:
 - 1) Premium and category of coverage for the applicable benchmark plans used to compute advance credit payment and period of coverage it was in effect;
 - 2) total premium for the coverage without reduction for advance credit payments or cost sharing;
 - 3) Aggregate amounts of any advance credit payments or cost sharing reductions;
 - 4) name, address, and taxpayer identification number of the primary insured and every person covered under the policy;
 - 5) All information provided to the HBE at enrollment or during the taxable year needed to determine eligibility for and the amount of the premium tax credit.



Questions