

**Summary of Draft Regulations for State Exchange Operations
Released in July and August 2011 by
The Centers for Medicare and Medicaid Services (CMS)
and the U.S. Department of the Treasury**

Health Insurance Exchanges and Qualified Health Plan Standards
Risk Adjustment, Risk Corridors, and Reinsurance Standards
Medicaid Eligibility Expansion and Coordination Standards
Premium Tax Credits and Cost Reduction Subsidies

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Introduction

The Centers for Medicare & Medicaid Services (CMS) – the federal agency responsible for Medicare, Medicaid, and children’s health, survey, certification, and quality improvement – released a 360-page draft of proposed regulations on state health exchange functionality, oversight standards, reinsurance, and risk adjustment standards on July 11, 2011, in connection with national health reform and the passage of the Patient Protection and Affordable Care Act (PPACA). Final regulations will likely be released in Q4 2011.

On August 12, 2011, CMS released additional draft regulations concerning state Medicaid and exchange eligibility determinations. On the same date, the U.S. Department of the Treasury released a notice of proposed rulemaking (NPRM) concerning the calculation and administration of premium tax credits in 2014 to make health insurance more affordable for lower- and middle-income citizens.

As part of the effort of *CHOICE* Administrators Exchange Solutions and The Word & Brown Companies to keep regulators, policymakers, brokers, and other key stakeholders up to date on these health reform regulations, we present a summary of the July 2011 and August 2011 preliminary guidelines and key provisions. Our summary is organized as follows:

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Health Insurance Exchanges and Qualified Health Plan Standards

Background

The Centers for Medicare & Medicaid Services (CMS) released two notices of proposed rulemaking (NPRM).

- State Exchange Operation and Oversight Standards, which includes:
 - Standards for selection and oversight of qualified health plans (QHP);
 - Standards for participation in Small Business Health Options Program (SHOP);
 - Minimum requirements for QHPs sold through a Health Insurance Exchange (hereafter referred to as the Exchange).
- Standards for transitional state-based reinsurance program, including:
 - Standards for the Individual market;
 - Standards for state-based risk adjustment program;
 - QHP standards for temporary federal risk corridors program.
- Issues Not Addressed:
 - Standards for Individual and SHOP participation in the Exchange;
 - Eligibility for premium tax credits and cost-sharing reduction payments;
 - Standards for exempting individuals from the mandate (to participate in the Exchange);
 - Standards for essential health benefits (EHB), which includes ambulatory patient services, emergency services, hospitalization, maternity and newborn care, prescription drugs, rehabilitative services, et. al;
 - Quality standards for QHPs.

State Exchange Certification

- By 1/1/13, the U.S. Department of Health and Human Services (HHS) will determine whether a state's exchange is in compliance, and HHS may provide either "conditional" or "full approval" depending on progress toward meeting compliance.
- State exchanges in operation prior to 1/1/10 (such as Massachusetts and Utah) will be presumed to be in compliance as long as coverage rates are no less than the projected percentage after PPACA implementation.

Exchange Requirements

- Exchanges must be able to perform key functions outlined in the PPACA, including:
 - Enrollment;
 - Premium Payments;
 - Navigator Program;
 - Consumer Decision Support Tools;
 - SHOP plan for businesses (with option to cover up to 100 employees);
 - Carrier certification and contracting.
- Exchanges must comply with Internal Revenue Service regulations related to advance payments of premium tax credit (which are to be defined).
- Exchanges must operate a reinsurance program.
- Entire state must be covered by one or more Exchanges.
- Exchanges must be established by a governmental agency or a non-profit entity with demonstrated experience in the Individual and Small Group markets. Health insurance carriers are ineligible to operate an Exchange, but state Medicaid agencies may operate an Exchange.
- Exchanges must consult with a broad range of consumer and employer stakeholders. CMS encourages consultation with representatives of advocacy groups for individuals with disabilities, those with culturally and linguistically appropriate needs, and Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries.
- Exchanges are prohibited from creating rules that conflict with federal Exchange regulations or pre-empt insurance reforms in PPACA, and from engaging in discrimination in outreach and enrollment activities.

Exchange Functions

- Exchanges must perform key functions, including certification of exemptions from mandate and penalty, eligibility determination, and establishing eligibility appeals processes (to be defined).
- Exchanges must “evaluate quality improvement strategies and assessments and ratings of healthcare quality and outcomes” (to be defined further).

Navigator Programs

- Exchanges are required to make grants to public or private entities working as “Navigators.” Navigators must meet applicable licensing standards and must not have any conflicts of interest when performing functions as Navigators.
- Exchanges must select Navigators from at least two of the following categories:
 - Community and consumer-focused non-profit organizations;
 - Trade, industry, and professional organizations;
 - Commercial fishing, ranching, and farming industries;
 - Chambers of commerce;
 - Unions;
 - SBA partners;
 - Licensed agents and brokers;
 - Other public or private entities meeting requirements including Indian tribes, urban Indian organizations, and State or local human services agencies.
- Navigators are prohibited from being insurance carriers or from receiving direct or indirect compensation from carriers based on enrollment.
- Navigators may not be funded with federal Exchange operating monies.

Individual and Family Enrollment

- Initial open enrollment period will be 10/01/13 through 02/28/14.
- Persons enrolled as of 12/22/13 must be assured of 01/01/14 effective dates.
- Enrollments completed between the 1st and 22nd of the month must be effective on 1st day of the following month.
- Enrollments between the 23rd day and the end of the month may be effective either the 1st day of the following month or 1st day of month after that.
- Exchanges must have annual open enrollment periods for QHP enrollment and must give current enrollees advance written notice of annual open enrollment.
- Individuals may be restricted to these enrollment periods **unless** they qualify for a special enrollment period based on a triggering event:
 - Loss of minimum essential coverage (exceptions are failure to pay premium on a timely basis – including COBRA premiums, or where rescission is allowed);
 - Loss or gain of dependent or change in dependent status through marriage, birth, adoption, or placement for adoption;

Individual and Family Enrollment (cont'd)

- Becoming a citizen, national, or lawfully present individual;
- Correction of enrollment status due to unintentional error, misrepresentation, or inaction by Exchange or HHS;
- Proof by enrollee that QHP of current enrollment had material contract violation with respect to that enrollee;
- Determination of new eligibility or ineligibility for advance payments of premium tax credit or eligibility change for cost-sharing reductions;
- Permanent move resulting in access to new QHPs;
- Status as Indian entitling individual monthly enrollment change in QHP; or
- Other exceptional circumstances as provided by Exchange or HHS.

Small Business Health Options Programs (SHOPs)

- Must allow qualified employers to choose a level of coverage under which all qualified employees have a choice of any available plan, but may also use a different method to allow qualified employers to offer plan choices to employees.
- Must allow qualified employers to purchase coverage for qualified employees through the SHOP; employers must be a small firm (100 or fewer employees, with state flexibility (until 2016) to limit size to 50 employees).
- Eligibility for employers and employees based on a single employer application and a single employee application.
- Required to process employee applications and facilitate enrollment of qualified employees.
- SHOPs must:
 - Transmit enrollment information to QHPs;
 - Notify employees of coverage effective dates;
 - Administer payments;
 - Terminate non-compliant employers;
 - Receive and maintain enrollment and participation records;
 - Reconcile information monthly; and
 - Notify employer of employee coverage termination.
- Administer enrollment periods and ensure enrollment transactions are sent to QHP carriers
 - CMS proposes the initial SHOP enrollment begin 10/01/13 for 01/01/14 effective dates (the same as for Individuals).

Small Business Health Options Programs (cont'd)

- Employees must have annual open enrollment period after employer's annual election period; newly hired employees may seek coverage beginning the 1st day of employment, irrespective of open enrollment period.
- Exchanges must allow qualified individuals to pay premiums directly to QHP carrier. Carriers must accept aggregated premiums by qualified employers, and may establish electronic funds transfer (EFT) processes.

Qualified Health Plan Certification

- Exchanges must ensure carriers meet two basic requirements to be certified as a Qualified Health Plan (QHP):
 - Carrier must demonstrate compliance with minimum certification requirements; and
 - Carrier offering must be in the best interest of qualified individuals and small employers.
- To determine whether carrier offering is in best interest of two key segments (as noted above), the Exchange may choose optional strategies:
 - “Any qualified plan”;
 - Competitive bidding;
 - Case-by-case negotiation;
 - HHS suggests that competitive bidding may provide best value and quality for individuals and small businesses; and
 - Exchanges are permitted to establish additional criteria.
- Exchange must ensure QHP offers sufficient provider choice.
 - Exchanges are given discretion to establish network adequacy standards with no minimum requirements specified;
 - Access and adequacy standards have been established by the National Association of Insurance Commissioners (NAIC).

Qualified Health Plan Standards

- Carrier participation in Exchange is conditioned on each plan offered being certified as a QHP. Standards do not supersede state law and do not exempt carriers from any state law or regulations applicable to carriers. States may establish more stringent standards at their discretion.
- Each QHP must comply with benefit design standards.
- Carriers must be licensed and in good standing in each state (in which they operate).

Qualified Health Plan Standards (cont'd)

- Carriers must comply with quality improvement standards and disclosure and reporting of quality and outcomes measurements, including member satisfaction surveys (further guidance to be provided).
- Carriers are allowed to vary premiums for a QHP or multi-state QHP by geographic rating area.
- Carriers must charge the same premium rate for a plan, irrespective of whether the benefit plan is offered through the Exchange, directly to the consumer, or through a broker.
- Carriers must cover all of the following groups using one or more combinations, including:
 - Individuals;
 - One-adult families with a child (or multiple children);
 - Two-adult families;
 - All other families.
- Family rates using age or tobacco rating may only apply to the portion of the premium that is attributable to each family member.
- Non-discrimination Provision – carriers may not discriminate on the basis of race, color, national origin, disability, age, sex, gender, or sexual orientation. Non-discrimination practices apply but are not limited to marketing, outreach, and enrollment.

Marketing

- Carriers and their representatives must comply with state laws and regulations concerning marketing; they are prohibited from practices that discourage enrollment of individuals with higher-than-average health needs.
- Exchanges should consider each carrier's marketing practices in determining whether a carrier offering is in the best interest of individuals and small businesses.

Network Adequacy

- Carriers must ensure that provider networks include essential providers and comply with network adequacy standards of the Public Health Service Act (PHSA). In the PHSA, carriers are required to furnish coverage unless individual resides outside of the carrier's service area or the carrier is at enrollment capacity.
- Carriers must make QHP provider directories available, and they must identify providers with closed panels.

Essential Community Providers

- Carrier networks must include a “sufficient number” of essential community providers (ECPs) that predominantly serve low-income, medically underserved individuals.
- ECPs qualify for special prices from prescription drug manufacturers and include:
 - Federally qualified health centers;
 - Community health centers;
 - Title X (family planning program) grantees;
 - Ryan White Act grantees;
 - State-operated AIDS prescription drug purchasing programs;
 - Black lung clinics;
 - Hemophilia diagnostic treatment centers;
 - Native Hawaiian and Indian Health Service grantees; and
 - Other facilities serving low-income, critical access, and rural referral centers.

Segregation of Abortion Services

- Unless prohibited by state law, carriers must determine whether a QHP covers abortion services. QHPs are not required to cover abortion service as “essential health benefits.”
- If a QHP provides services for which federal funding is not permitted, the carrier must not use any amount of funding attributable to the premium and cost-sharing tax credits.
- Carriers must collect a separate payment from enrollees for the actuarial value of services for which federal funding is prohibited; those funds must be deposited in a separate account.
- QHP carriers may not discriminate against a health care provider or facility because of its unwillingness to pay for or provide or refer for abortion services.
- PPACA provisions shall not be interpreted to impact state laws concerning abortion coverage, funding, or procedural requirements.
- PPACA does not impact requirements under the Emergency Medical Treatment and Active Labor Act, which was enacted by Congress in 1986.

Risk Adjustment, Risk Corridors, and Reinsurance Standards

Background

State Exchanges must establish a transitional reinsurance program for the first three years of Exchange operations (2014 through 2016). HHS must establish a transitional risk corridor program that will apply to QHPs in the Individual and Family plan and Small Group markets for 2014-2016. Each state may establish an ongoing program for risk adjustment for all non-grandfathered plans in the Individual and Small Group markets inside and outside of the Exchange. If states establish reinsurance or risk adjustment standards that differ from those established by HHS, the state must notify carriers and stakeholders and describe the specific reinsurance or risk adjustment parameters to be utilized.

Standards for Transitional Reinsurance Program for Individual Market

- Each state Exchange must establish a transitional reinsurance program (for the 2014-2016 time period) to stabilize premiums in the Individual market and to protect health plans from adverse selection.
- Carriers and third party administrators (TPAs), who are working on behalf of administrative services only groups, must make contributions to a non-profit reinsurance entity to support Individual plan carriers from adverse selection.
- A state not establishing an Exchange (and defaulting to the federal Exchange) may establish a reinsurance program. For states who elect to do neither, HHS will facilitate the required reinsurance program.
- The reinsurance entity collects monies from carriers using a national uniform contribution rate (as a percentage of premium applied to all contributing carriers and TPAs).
- An Individual benefit plan that is not “grandfathered” becomes eligible for a reinsurance reimbursement when the plan’s claim costs exceed a specific attachment point (guidance on this matter is to be provided in the future).
- States must ensure the reinsurance entity collects enough claim cost information from participating carriers to calculate reinsurance payments. State must ensure that carrier requests for reimbursement are valid – and that payments do not exceed contributions to the reinsurance pool.
- A state is required to modify or eliminate any state-based high risk pool to comply with these regulations or to coordinate the high risk pool with the new reinsurance pool under these regulations.

Standards for Risk Adjustment Program

- State Exchanges are eligible to operate a risk adjustment program. HHS will operate such programs for states that do not establish Exchanges.
- State Exchanges must be ready to calculate risk adjustment charges and payments for the 2014 benefit year. States may subcontract risk adjustment functions to an external party.
- The risk adjustment methodology used by the state Exchange must be federally certified by HHS.
- The state, or HHS on behalf of the state, must collect risk-related data to determine individual carrier risk scores. States must implement security and privacy standards for individually identifiable information. Any state with an all-payor claims database (including but not limited to Colorado and Massachusetts) operational by 01/01/13 may apply for waiver from HHS minimum data collection standards.

Carrier Standards for Transitional Reinsurance Program

- Carriers and TPAs (“contributing entities”) must make financial contributions to an appropriate reinsurance entity. A reinsurance-eligible carrier may make a request for reinsurance payment when members’ claims meet established criteria for such payment.

Qualified Health Plan Standards for Temporary Risk Corridor Program

- QHP carriers must comply with the risk corridor program for calendar years 2014 through 2016.
- QHPs receive payments from HHS under the program if the carrier’s allowable costs for any benefit year are more than 103% – but not more than 108% – of the target amount. The amount of this payment will be equal to 50% of the target amount in excess of 103% of the target amount. When a QHP’s allowable costs are more than 108% of target amount, payment equals the sum of 2.5% of the target amount plus 80% of allowable costs in excess of 108% of the target amount.
- If a QHP’s allowable costs for any benefit year are less than 97% – but not less than 92% – of the target amount, the carrier must submit to HHS a payment equal to 50% of the difference between 97% of the target amount and the allowable costs. If a carrier’s allowable costs are less than 92% of the target amount, the carrier must submit to HHS a payment equal to the sum of 2.5% of the target amount plus 80% of the difference between 92% of the target and allowable costs.

Qualified Health Plan Standards for Temporary Risk Corridor Program (cont'd)

- To verify payment amounts, QHP carriers must submit to HHS data on collected premiums for each QHP offered by the carrier. Reported premiums must be adjusted for payments made or received for risk adjustment, reinsurance, and paid user fees. Carriers must submit to HHS allowable costs incurred for each offered QHP.

Carrier Standards for Risk Adjustment Program

- Carriers offering risk-adjusted benefit plans must submit required risk adjustment data to the state. This data must include:
 - Claims and encounter data for rendered services;
 - Enrollment and demographic data; and
 - Prescription drug utilization data.
- In their provider and supplier contracts, carriers are allowed to include provisions requiring submission of specific required risk adjustment data in a manner established by the state. Penalties for non-compliance may be included. Carriers owing risk adjustment payments will be notified by the state of the amount owed and must remit these payments to the state in a timely manner.

Medicaid Eligibility Expansion and Coordination Standards

State Medicaid Eligibility Determination

- Many states cover 60 or more mandatory and optional eligibility categories.
- Four eligibility categories will apply in 2014:
 - Parents and caretaker relatives with incomes exceeding 133% of FPL;
 - Pregnant women;
 - Children;
 - Adult expansion population (individuals under 65 at or below 133% FPL).
- PPACA adds a new category: Adults under age 65 with Modified Adjusted Gross Income (MAGI) at or below 133% of the Federal Poverty Level (FPL). [Note: 5% of income is disregarded under statute, so eligibility level is effectively 138% of FPL.]
- States will receive 100% federal funding for newly eligible enrollees in this category beginning in 2014 and continuing through 2016. The federal funding begins an incremental decline in 2017 (in as-yet undefined increments), phasing down to 90% in 2020 and thereafter.

Medicaid Eligibility Determination (cont'd)

- The federal individual coverage mandate requires citizens above the filing limit (at or below 90% of FPL) to obtain health insurance (which could include Medicaid coverage).
- Expanded Medicaid eligibility is based on MAGI without inclusion of other assets.
- Current income counting rules and disregards connected to MAGI.

Note: Social Security payments are not treated as income in MAGI calculation.

Focus on Coordination and Seamlessness

- System alignment between state Medicaid and state Exchanges is underscored.
- Individuals should be able to apply for either program and be subject to the same income rules (in order to be directed to right program).

Eligibility Determination Differences Between Medicaid and Treasury Tax Credits

- Medicaid eligibility determined by current need.
- Treasury tax credit eligibility based on annual income as verified at year's end tax filing.
- Medicaid eligibility determined for 12-month period, and, while reasonably anticipated income changes may be determined, eligibility is based on income at time of application.
- Certain income included for tax credit calculation may be disregarded for Medicaid eligibility (e.g., certain lump-sum payments).
- In some examples, household composition is treated differently between Medicaid and tax credit calculation. Chance for confusion an obstacle for "seamless" enrollment coordination.
- A single streamlined application form that may be filed online (or by paper) will be used by all applicants for "insurance affordability programs" (e.g., Medicaid, Children's Health Insurance Program (CHIP), basic health plan (where applicable), premium tax credits, and cost-sharing payments) through the Exchange.
- If applicant is determined to be ineligible for Medicaid, eligibility for tax credits is automatically determined.

Eligibility Determination Differences Between Medicaid and Treasury Tax Credits (cont'd)

- States may rely on self-attestation for Medicaid eligibility, except as follows:
 - Citizenship information verified by Social Security Administration;
 - Immigration status verified by Homeland Security;
 - Income verified via IRS through process established by HHS.
- Medicaid eligibility re-determined every 12 months. “Redets” may be reviewed more often for qualifying events.
- If Exchange determines applicant is eligible for Medicaid based on MAGI, state must enroll individual without further eligibility determination.
- If Medicaid eligibility not based on MAGI, Exchange may screen applicant and transmit application to Medicaid.
- States are only eligible for enhanced matching funds for newly eligible individuals and families under pre-PPACA rules.
- Three approaches:
 - Using thresholds across category groups to approximate December 2009 standards;
 - Using statistical sampling techniques; or
 - Using extrapolation from data sources such as the Medical Expenditure Panel Survey (MEPS) or Medicaid Statistical Information System (MSIS) data.

Determining Exchange Eligibility

- In the eligibility verification process, if an inconsistency of information is identified, the Exchange must provide the applicant with written notice – and the Exchange may give the applicant up to 90 days to resolve the problem. The Exchange may provide interim premium assistance during this 90-day appeal period; however, the applicant must repay any provided assistance if eligibility may not be established. Future regulations will define the appeal process.
- Taxpayers receiving tax credits or cost-sharing payments must inform the Exchange of eligibility changes within 30 days. If a tax credit recipient is determined ineligible, tax credits will end but Qualified Health Plan (QHP) enrollment continues for another month to allow enrollee coverage options. A re-determined eligible enrollee will remain enrolled in the same QHP unless the enrollee changes his or her QHP during open enrollment.

Determining Exchange Eligibility (cont'd)

- The Exchange must notify enrollee's QHP if tax credits or cost-sharing subsidies are reduced or eliminated.
- The Exchange must notify enrollee's employer if it determines the employer does not provide minimum essential benefits (e.g., "mini med" plans) or that coverage is unaffordable.

Premium Tax Credits and Cost Reduction Subsidies

Background

Treasury issued proposed regulations under which the new premium tax credits will be calculated and administered beginning in 2014. The objective of the tax credits is to help make health insurance more affordable for uninsured lower- and middle-income Americans.

Basic Rules

Beginning in 2014, individuals ineligible for health insurance coverage through their employer or through a government program (such as Medicaid or Medicare), and who have a modified adjusted gross income (MAGI) of between 100% and 400% of the Federal Poverty Level (FPL), will be eligible for refundable premium tax credits.

Credits will be paid on a monthly basis directly to the Qualified Health Plan in which the person enrolls via the Health Insurance Exchange (hereafter referred to as the Exchange).

To be eligible for the tax credit, an individual must be an "applicable taxpayer" (i.e., he or she must file a tax return irrespective of whether taxes are owed), must meet financial eligibility requirements, must file a joint return (if married), and must not be claimed as a dependent on anyone else's tax return.

Individuals who have an offer of coverage through their employer are generally ineligible for a tax credit, unless their employer-sponsored insurance (ESI) is unaffordable (i.e., costs exceed 9.5% of income) or it does not provide minimum value (i.e., it covers less than 60% of the actuarial costs of essential minimum benefits).

Calculating the Amount of Tax Credit

The first step is to calculate summation of total MAGI for all members of the household required to file tax returns. (Income for dependents who are not required to file returns may be ignored.)

Household must spend a certain percentage of MAGI, determined by a table found in statute and regulation, on qualified health coverage.

For 2014, applicable percentages begin at 2% for taxpayers with income below 133% of FPL and increase to 9.5% for taxpayers with incomes up to 400% of FPL.

The tax credit will be the difference between the amount calculated by applying the applicable percentage to household income (ranging from 2% to 9.5%) and the actual monthly premium cost of the “benchmark plan” (i.e., the second lowest-cost Silver plan – the plan with an actuarial value of 70%) available to the taxpayer, adjusted for age.

Example: Family of Four with \$50,000 annual income purchases benchmark plan.

– Income as percentage of FPL:	224%
– Expected family contribution:	\$3,570
– Benchmark Plan Premium:	\$9,000
– Premium Tax Credit:	\$5,430 (\$9,000 - \$3,570)

The FPL used to calculate the premium tax credit will be that in effect on the first day of open enrollment for the taxable year, which means it will be usually the FPL for the year prior to the year in which the credit is awarded.

The final actual amount of the tax credit will be based on household income as determined on the annual income tax return when “reconciliation” occurs. If household income turns out to be greater than projected, the final tax credit may be greater or less than the amount already paid. If taxpayer’s return shows eligibility for a greater tax credit, the taxpayer will get a refund. If the tax credit was greater than the taxpayer was entitled to, repayment to the government will be required. If final income exceeds 400% of FPL, even by \$1, the entire tax credit must be paid back.

Overpayments may be common – due not only to changes in income and household composition over the course of a year, but also because a person who loses or gains a high income job may end up with high end-of-year income (e.g., bonus payment) resulting in income over 400% of FPL, which requires repayment of the entire tax credit.

Exchanges will need to communicate to enrollees the importance of prompt reporting of changes in income or household composition.

Impact on Employer-Sponsored Insurance (ESI)

Taxpayers offered employer-sponsored insurance (ESI) but who would pay more than 9.5% of household income for their share of premiums may decline coverage and receive a tax credit to purchase coverage through the Exchange.

In this instance, the employer owes a penalty of \$3,000 for each affected employee up to a maximum equal to a total of \$2,000 multiplied by the number of full-time employees in excess of 30. The statute is unclear whether the 9.5% applies only to the cost of individual coverage or also applies to the cost of family coverage.

Taxpayers offered individual-only coverage for less than 9.5% of total household income are ineligible for a tax credit, even if family coverage is unaffordable. There is some risk of employers manipulating premiums to raise the cost of family coverage to keep individual coverage under the 9.5% threshold.

An employee who opts out of ESI is ineligible for a tax credit, even if coverage is unaffordable.

An employee is considered to have ESI even though enrollment is currently closed if the employee could have enrolled during the prior open enrollment period.

If the Exchange determines ESI is unaffordable, the employee is eligible for a tax credit for the entire year, even if subsequently it is determined ESI would have been affordable. In this situation, it is anticipated the employer will not be penalized.

A “safe harbor” for employers exists if ESI costing less than 9.5% of income ends up costing more than 9.5% (because, for example, a family member had negative income).

Availability of COBRA does not disqualify a taxpayer from receiving a premium tax credit unless the taxpayer actually purchased COBRA.

Coordination with Public Programs

A taxpayer is ineligible for a tax credit for any member of his or her household eligible for a government insurance subsidy. Individuals who apply for government coverage are disqualified from receiving tax credits once their application is approved, even if retroactively.

A taxpayer is only eligible for a tax credit for the months the taxpayer’s household is actually enrolled in a QHP through the Exchange.

Coordination with Public Programs (cont'd)

Divorced spouses have discretion in allocating credits and household income.

A taxpayer parent may claim a tax credit for a child if the taxpayer claims that child as a dependent, even though another divorced or separate parent is legally obligated to pay for the child's health insurance.

As additional regulations are developed or proposed (and announced) in connection with the implementation of Health Insurance Exchanges and the Patient Protection and Affordable Care Act, *CHOICE* Administrators Exchange Solutions and The Word & Brown Companies will release additional summaries, which will be posted to our Exchange website (www.choicadmin.com/exchanges).