HealthSource RI Policy Manual
2018 - 2019

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Chapter 1: Introduction

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. The ACA makes the following major changes to how individuals, families and businesses secure health coverage:

- Providing funding to the states to establish state-based health benefits exchanges to facilitate households' purchases of affordable health insurance coverage through an exchange.
- Creating new federal advanced premium tax credits (APTCs) to help low and moderate-income households purchase coverage.
- Creating new federal cost sharing reductions (CSRs) for individual and families purchasing through an exchange to reduce the out-of-pocket costs households below 250 percent of the Federal Poverty Level (FPL) face when using their health insurance plans.
- Expanding Medicaid for adults without children up to 133% of FPL,[1] and making other changes to Medicaid and Rite Care.
- Creating new ways for consumers to shop for health insurance coverage.
- Making important reforms to the private insurance market so that, for example, people cannot be denied coverage solely because they have a pre-existing condition.
- Requiring households to have health coverage or make a shared responsibility payment, or obtain an exemption from the shared responsibility payment if eligible.

In June of 2015, the Rhode Island General Assembly submitted, and Governor Gina Raimondo approved, an operating budget containing a provision establishing HealthSource RI as a division of the Rhode Island State Department of Administration (DOA). HealthSource RI's organic statute is codified at Rhode Island General Laws, Chapter 42-157, Rhode Island Health Benefit Exchange. HealthSource RI's operations will be supported by a combination of budgetary allocations and an assessment on carriers, and may be supplemented by a general revenue allocation.

In September of 2011, Governor Lincoln Chafee codified some of the major components of the ACA into Rhode Island law through an Executive Order establishing HealthSource RI as the state's first ever health insurance exchange. HealthSource RI allows households to apply for and purchase health insurance, apply for advanced premium tax credits (APTCs) to lower the costs of insurance, apply for an exemption from the shared responsibility payment, or apply for MAGI Medicaid coverage. Small businesses can purchase coverage for their employees through HealthSource RI's Small Business Health Insurance Options Program or SHOP.

Since the establishment of HealthSource RI, Rhode Island has developed an integrated approach to health reform under the ACA, incorporating HealthSource RI with the state Medicaid program. In the months and years to come, other human services programs operated through the Executive Office of Health and Human Services (EOHHS) and the Department of Human Services (DHS) will also become integrated into this new approach to health care. This work is being done to serve a broad customer base, including Medicaid-eligible individuals and families, subsidy-eligible households, Rhode Island residents purchasing coverage without

[1] The effective eligibility level is 138% FPL.

subsidies, small employers and their employees, and employees of large employers.

HealthSource RI supports health reform efforts aimed at promoting the well-being of Rhode Islanders and providing enhanced access to high quality, coordinated care at a reasonable, predictable cost. The mission of HealthSource RI is to serve as a robust resource for Rhode Islanders and Rhode Island businesses to learn about and easily compare the quality of affordability of their health insurance options, enroll in coverage and, if eligible, access federal tax credits for coverage.

The implementation of the ACA in Rhode Island, and establishment of HealthSource RI, has created the need for new policies and procedures at the state level. Such rules and procedures have been promulgated pursuant to the authority set forth in RIGL §23-1-1 and Executive Order 11-09, pursuant to RIGL. §§ 42-62-16 *et. seq*.

The purpose of this document is to provide a public resource to clarify the operational policies of HealthSource RI, including, but not limited to:

- Determining eligibility for Qualified Health Plans (QHPs),
- Determining eligibility for APTCs and CSRs,
- Guidelines for enrolling and dis-enrolling from coverage,
- Enrollment and payment deadlines for health coverage, and
- Rules concerning exemptions from the shared responsibility payment.

Chapter 2: Eligibility for Qualified Health Plans

A. Overview of Qualified Health Plans

Individuals may enroll in a health insurance plan through HealthSource RI. All health insurance plans offered through HealthSource RI are certified, provide a comprehensive set of health benefits, follow established limits on cost sharing, and meet other requirements set by state and federal law. The health insurance plans offered through HealthSource RI are referred to as Qualified Health Plans (QHPs). To be certified, QHPs must include a set of comprehensive health care services referred to as essential health benefits (EHBs) in 10 categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.

QHP coverage may include benefits in addition to the above essential health benefits. Individuals are also able to buy dental-only coverage. Coverage through a QHP is available to all individuals who meet the eligibility standards, regardless of their health status and any pre-existing medical conditions.

All individuals who meet the QHP eligibility standards described below are eligible for coverage regardless of their income. However, applicants that anticipate having annual household income of 100% to 400% of the Federal Poverty Level (FPL) may be eligible to receive financial help from the federal government if they lack other affordable coverage options. Applicants that anticipate having annual household income of 100% to 250% of the FPL may also be eligible for cost sharing reductions that reduce the out-of-pocket costs applicants pay for health coverage, such as deductibles, co-payments, and coinsurance for covered services. Applicants who project an annual household income above 400% of the FPL are not eligible for financial assistance but still may purchase a QHP plan at full price. For more information about financial assistance to help purchase a QHP, see Chapter 4.

B. Eligibility for a Qualified Health Plan

1) Overview of QHP Eligibility

Individuals are eligible to enroll in a QHP if they are:

- A Rhode Island resident[2]

[2] 220-RICR-90-00-1.5(B)(3)

- A U.S. citizen, a national, or lawfully present,[3] **and**
- Not incarcerated[4]

2) Residency

a) Overview of Residency Requirements

Only Rhode Island residents and their family members may enroll in a QHP through HealthSource RI.[5] There are certain requirements that individuals must meet to be considered a Rhode Island resident and these requirements vary slightly for children (aged 0-20) versus adults (21 and older).

i) Adults Age 21 and Over

Individuals ages 21 and over who are not living in an institution,[6] are capable of indicating intent, and are not receiving an optional state supplementary payment,[7] may enroll in a QHP through HealthSource RI if they:

- Currently live in Rhode Island, and either
- Intend to reside in Rhode Island, even if they do not presently have a fixed address; or
- Entered Rhode Island with a job commitment or seeking employment (whether or not they are currently employed). [8]

For individuals who live in an institution, who are not capable of indicating intent, or who receive an optional State supplementary payment, Medicaid residency rules apply.[9]

Example: A young woman who recently graduated from college is living with various friends in Providence while looking for a job. Even though she does not have a fixed address, she is in the state presently, and is seeking employment. She therefore qualifies as a Rhode Island resident and is eligible to purchase a QHP through HealthSource RI.

ii) Children Under Age 21

Individuals under the age of 21 who are not living in an institution,[10] who are not eligible for Medicaid based on receipt of assistance under title IV-E of the Social Security Act,[11] are not emancipated, and not receiving an optional State supplementary payment,[12] may enroll in a QHP through HealthSource RI if they:

- Reside in Rhode Island, including without a fixed address; or

[3] 220-RICR-90-00-1.5(B)(1)
[4] 220-RICR-90-00-1.5(B)(2)
[5] 45 CFR 155.305(a)(3)
[6] as defined in 42 CFR 435.403(b)
[7] as addressed in 42 CFR 435.403(f)
[8] 45 CFR 155.305(a)(3)(i)
[9] 45 CFR 435.403
[10] as defined in 42 CFR 435.403(b)
[11] as addressed in 42 CFR435.403(g)
[12] as addressed in 42 CFR435.403(f)

- Reside with a parent or caretaker relative who lives in Rhode Island. [13]

For individuals who live in an institution[14], who are not eligible for Medicaid based on receipt of assistance under Title IV-E of the Social Security Act, are not emancipated, and are not receiving an optional State supplementary payment, Medicaid residency rules apply.[15]

b) Rules for Tax Households with Members in Multiple Exchange Areas

In general, if a tax filer is a Rhode Island resident, all members of their tax household may enroll in a QHP through HealthSource RI. In certain situations, individuals who are part of the same tax household may live in different states.

In cases where all of the members of a tax household are not within the same state, any member of the household may enroll in a QHP through an Exchange in any of the states for which one of the tax filers meets the residency standard. [16] However, if both spouses in a tax household enroll in a QHP through the same Exchange, their tax dependent(s) may **only** enroll in a QHP through the same Exchange **or** through the Exchange that services the area in which the tax dependent resides.

Example: Consider a married couple with a daughter who goes to college in New York. The husband lives in Rhode Island and the wife in Washington, D.C. The married couple enrolls in a QHP through the HealthSource RI. Their daughter has two options: 1) She can enroll in a QHP through HealthSource RI; or 2) She can enroll in a QHP through the New York Exchange. However, she cannot enroll in the D.C. Exchange even though her mother is a resident of D.C.

c) Treatment of Temporary Absences

For individuals otherwise meeting the residency requirements to be eligible to purchase a plan through HealthSource RI, a temporary absence from Rhode Island does not affect their eligibility so long as they intend to return to Rhode Island when the purpose of the absence has been accomplished.[17]
Acceptable instances of temporary absences from Rhode Island include:

- Vacation
- Employment or job search
- Natural disaster or catastrophic event
- Personal or family emergency
- Visits with non-custodial parents
- Visits with children in the custody of another parent.
- Military service
- Hospitalization

[13] 45 CFR 155.305(a)(3)(ii)
[14] 42 CFR 435.403(b)
[15] 45 CFR 435.403
[16] 45 CFR 155.305(a)(3)(iv)
[17] 45 CFR 155.305(a)(3)(iii); 42 CFR 435.403(j)(3)

Example: An early retiree (under age 65) lives in Rhode Island but spends his winters in Florida. He may enroll in a QHP offered through the HealthSource RI even though he will be temporarily out of the state during the year.

3) Citizenship and Immigration Status

To be eligible for a QHP, an individual must be a U.S. citizen, a derived citizen, a U.S. national, or lawfully present. Any lawfully present immigrant who has not violated the terms associated with their immigration status and who plans to file taxes is eligible to purchase coverage through HealthSource RI and be evaluated for eligibility for Advanced Premium Tax Credits.[18]

a) U.S. Citizen, Derived Citizen and U.S. National

A U.S. citizen is an individual who has U.S. citizenship, either by birth or by naturalization.[19] U.S. citizenship information is verified electronically with the Social Security Administration.

A derived citizen is an individual who obtains citizenship through a parent. For example, a child born outside of the U.S. to a U.S. citizen is a derived citizen.

A small number of individuals are U.S. Nationals but are not U.S. citizens.[20] Individuals who are U.S. nationals have naturalization certificates.

b) Lawfully Present

An individual is lawfully present as defined by the Affordable Care Act if they are a "qualified" immigrant or are not a citizen but have permission to live and/or work in the U.S.[21] Individuals who are lawfully present include, but are not limited to:

- Lawful Permanent Resident (LPR/Green Card holder)
- Asylee
- Refugee
- Cuban/Haitian Entrant
- Paroled into the U.S.
- Conditional Entrant Granted before 1980
- Battered Spouse, Child and Parent
- Victim of Trafficking and his/her Spouse, Child, Sibling or Parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Individual with Non-immigrant Status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)

[18] 45 CFR 155.305(a)(1)
[19] 8 U.S.C. 1401
[20] 8 USC 1452(b)(2)
[21] For a more complete listing of terms and concepts referenced in this Chapter, including the legal requirements for who qualifies as "lawfully present" and the definition of "qualified immigrants", please refer to 45 CFR 152.2 and 8 USC 1641.

- Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Deferred Action Status (Deferred Action for Childhood Arrivals (DACA) is not an eligible immigration status for applying for health insurance)
- Lawful Temporary Resident
- Administrative order staying removal issued by the Department of Homeland Security
- Member of a federally-recognized Indian tribe or American Indian born in Canada
- Resident of American Samoa[22]

There are a number of documents that serve as acceptable proof of an individual's lawful presence. A non-exhaustive list of these documents is included in table 1 below.[23]

Table 1. Example Documents Serving as Proof that an Individual is Lawfully Present

Documents
Permanent Resident Card (Green Card I-551)
Temporary I-551 Stamp (on passport or I-94, I-94A)
Machine Readable Immigrant Visa (with temporary I-551 language)
Employment Authorization Card (EAD, I-766)
Arrival/Departure Record (I-94, I-94A)
Arrival/Departure Record in foreign passport (I-94)
Foreign Passport
Reentry Permit (I-327)
Refugee Travel Document (I-571)
Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
Notice of Action (I-797)
Other documents or status types

4) Incarceration

In order to enroll in a QHP, individuals cannot be incarcerated, other than incarceration pending the disposition of charges.[24]

Individuals subject to home confinement may be eligible to enroll in a QHP on the Exchange if they are not otherwise able to access health services through a correctional institution.

C. Non Discrimination

[22] See https://www.healthcare.gov/immigrants/lawfully-present-immigrants/
[23] Visit https://www.healthcare.gov/help/immigration-document-types/ for a comprehensive listing of documents that can be used to show immigration status
[24] 45 CFR 155.305(a)(2)

Carriers may not, with respect to any QHP, discriminate on the basis of race, color, religion, national origin, disability, gender identity, sex, sexual orientation, or age.[25] Carriers may not, with respect to any QHP, discriminate on the basis of source of income, marital status, political affiliation, personal appearance, or health status. Carriers are not prevented from varying premium quotations by the age of an applicant in accordance with Federal and State law, or from managing medical utilization of enrollees to the extent that clinically appropriate standards of care may call for different treatment of individuals based on certain permissible characteristics. Carriers may not treat persons enrolled in its QHPs differently than persons enrolled in the same or similar Health Benefit Plans they offer in the marketplace outside HealthSource RI, except as specifically permitted by applicable laws and regulations.

[25] 45 CFR 156.200(e)

Chapter 3: Open Enrollment Periods, Special Enrollment Periods & Enrollment Effective Dates

Introduction

This Chapter will detail the annual open enrollment period, special enrollment periods, and enrollment effective dates for HealthSource RI's individual and SHOP markets. Part I of the Chapter begins by detailing the rules that apply to the individual market, while Part II outlines the rules that apply to the SHOP market.[26]

Part I: Overview of Enrollment in the Individual Market

HealthSource RI provides a specified period of time each year during which qualified individuals and their dependents can enroll in a QHP. This is called an "annual open enrollment period." Individuals must sign up and make a timely payment for their first month's premium during annual open enrollment in order to be covered for the upcoming coverage year.

For an individual who enrolls in a plan and pays the first month's premium by December 23, coverage is effective as of January 1 of the upcoming coverage year.

There are also special enrollment periods that allow individuals and their dependents to select a plan outside of the annual open enrollment period. In order to be eligible for what's known as a "special enrollment period," individuals must have experienced a qualifying life event described in Section C of this Chapter.

A. Annual Open Enrollment Period

1) Overview of Annual Open Enrollment Period

During the annual open enrollment period any qualified individual may enroll in a QHP for the upcoming coverage year. Members of the same household[27] who are eligible for a QHP may select and enroll in the same coverage. HealthSource RI provides a written annual open enrollment notification to each current enrollee no earlier than the first day of the month before the open enrollment period begins and no later than the first day of the open enrollment period.[28] Annual open enrollment periods last a minimum of thirty (30) days.[29] The "start" and "end" dates for each annual open enrollment period are set each year via federal regulation.[30]

B. Effective Dates for Coverage Purchased During Annual Open Enrollment

Qualified individuals must select a QHP, and HealthSource RI must receive the first month's premium in full by

[26] See Chapter 11 for information regarding SHOP enrollment periods.
[27] as the household is defined for APTC purposes in Chapter 4.
[28] 45 CFR 155.410(d)
[29] 220-RICR-90-00-1.6(B)(2)
[30] The initial Annual Open Enrollment period began October 1, 2013 and extended through March 31, 2014. The annual open enrollment period for the coverage year 2015 began November 15, 2014 and extended until February 15, 2015. The Annual Open Enrollment period for the coverage year 2016 begins on November 1, 2015 and extends until January 31, 2016.

the required date, in order to make coverage effective. [31] HealthSource RI establishes a deadline each year relative to the annual open enrollment period by which a qualified individual's first month's premium must be received in order to make coverage effective as of the first day of the upcoming coverage year.[32]

During each annual open enrollment period, HealthSource RI will notify enrollees of the payment deadline for coverage to begin January 1 of the upcoming coverage year.

Generally speaking, for subsequent months during open enrollment, plans selected and paid for by the 23rd of the month will have an effective coverage date of the first of the following month. Plans selected and paid for after the 23rd will have a coverage start date of the first of the second month following plan selection. Alternative plan selection dates employed by HealthSource RI shall be communicated formally during open enrollment.

Enrollees can set QHP coverage to start on the first day of a month. Enrollees are given options for selecting a coverage start date, depending on their triggering event for enrollment and the time of reporting the event. Coverage must start on the first day of the month, except in the case of certain events as discussed in Section D of this Chapter, for example birth. Applicants may make changes to their plan selection at any time during annual open enrollment and such changes will be effectuated by HealthSource RI in accordance with the coverage effective dates described in this chapter.

The below examples assume an annual open enrollment period spanning from October 1 – February 28. Annual open enrollment period timeframes are subject to change each year.

Example: Consider an enrollment selection made and payment received on November 20 during an annual open enrollment period. The earliest effective date of coverage would be January 1 of the upcoming coverage year, however customer could select a coverage start date of February 1 or March 1 if desired. Payment is due by the 23rd of the month before the coverage is to start.

Example: Consider an individual who selected a QHP on December 3 and wishes to set an effective date of coverage on February 1. For this start date, the individual's initial payment is due January 23. If payment is received on February 8 (after the payment due date for coverage effective February 1) the customer must update their application and select a new coverage start date from the available options. Payment will then be applied towards the newly selected coverage start month.

C. Special Enrollment Periods

Individuals and families may be eligible to enroll in a QHP through HealthSource RI outside of annual open enrollment as a result of a qualifying event.[33] There are nine categories of acceptable qualifying events, including:

1) *Loss of health coverage.* The qualified individual or his or her dependent:
    a. Loses minimum essential coverage;

[31] 220-RICR-90-00-1.6(C)
[32] 220-RICR-90-00-1.6(C)
[33] 45 CFR 155.420(d)

b. Loses pregnancy-related coverage; or
c. Loses medically-needy coverage.

In each of the circumstances described above, the individual or his or her dependent has 60 days after the loss of coverage to select a QHP.[34] Loss of coverage does not include voluntary termination, rescissions or failure to pay premiums on a timely basis (including COBRA premiums prior to exhausting COBRA coverage).

2) *Addition of a household member or dependent*. The qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, placement in foster care or as the result of a child support order or other court order.
3) *Loss of a household member or dependent*. The qualified individual loses a dependent, gets divorced, or the primary account contact passes away. The remaining household qualifies for a SEP as a result. Note documents for verification of death are required if person who passes away is the primary account contact and is discussed more in the verifications chapter.
4) *Change in Lawful Status*. The qualified individual, or his or her dependent, gains status as a citizen, national, or lawfully present individual.
5) *Enrollment Error by HealthSource RI's Determination*. The qualified individual's (or his or her dependent's) enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of HealthSource RI, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities.[35]
6) *Substantial Violation*. The enrollee, or his or her dependent, adequately demonstrates to HealthSource RI that the QHP in which he or she is enrolled substantially violated a material provision of its contract with the enrollee.
7) *Change in Insurance Affordability Program Eligibility*. The individual or dependent enrolled in a QHP or an eligible employer-sponsored plan becomes newly eligible or ineligible for Advanced Premium Tax Credits (APTCs), or experiences a change in eligibility for cost-sharing reductions.[36]
8) *Permanent Move*. The qualified individual or enrollee, or his or her dependent, gains access to new QHPs following a permanent move.
9) *American Indian Status.* The qualified individual is an Indian, as defined by Section 4 of the Indian Health Care Improvement Act and may enroll in a QHP or change from one QHP to another one time per month.
10) *Exceptional Circumstances*. The qualified individual or enrollee, or his or her dependent, demonstrates to HealthSource RI, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as HealthSource RI may provide.
11) *Loss of Dental coverage*. The Exchange retains the discretion to establish an enrollment in dental plan only for a loss of access to dental coverage by a member of one's household. Loss of dental coverage rules logic remains the same as that for health insurance, as described above, and does not include voluntary termination, rescissions or failure to pay premiums on a timely basis. Loss of dental coverage would allow the eligible household to purchase or add **dental coverage only** and would not be considered an opportunity to change health insurance enrollment, unless meeting some other

[34] 45 CFR 155.420(c). A special enrollment period under this category may not begin prior to the date of the qualifying event. Coverage will be backdated to the first of the month following the loss of coverage.
[35] In such cases, HealthSource RI may take such action to correct or limit the effects of the error, misrepresentation or inaction.
[36] In this circumstance, the individual or dependent has 60 days after the loss of eligibility in ESI coverage to select a QHP, retroactive to the first of the month after month in which coverage ended under an eligible employer-sponsored plan.

eligibility criteria as described elsewhere, Customers must call the Contact Center to apply for dental coverage only to utilize this triggering event.

For an individual to be eligible for coverage during a special enrollment period, HealthSource RI must receive the entire first month's premium on or before the last day of the special enrollment period.

Example: A woman loses her job and her health insurance on April 15. She will be given a 60-day special enrollment period to seek coverage in a QHP. The special enrollment period will end on June 15 and she must select and enroll in a plan by this date. Payment is due in full based on the payment rules (described elsewhere).
Example: A Rhode Island resident was temporarily in the country as a tourist, but gained official refugee status on June 18. He would be entitled to a 60-day special enrollment period to seek coverage in a QHP beginning June 18.

Example: An American Indian, as defined by Section 4 of the Indian Health Care Improvement Act, wishes to enroll in a new QHP. She would be eligible to enroll in a new QHP or change their QHP one time per month.
Example: A current customer switches jobs and becomes newly eligible for APTCs based on his new income. If a new eligibility determination was made on August 12, he would have 60 days from August 12 to enroll in and make payment for a new QHP.
Example: An enrollee has a pending eligibility determination due to lack of required documentation, but while waiting to receive these documents in order to submit them to HealthSource RI, the initial or annual open enrollment period closes. She may be granted a special enrollment period based on exceptional circumstances determined by HealthSource RI.

D. Special Enrollment Effective Dates

1) Regular Effective Dates for Special Enrollment Periods

For some categories of special enrollment events discussed above, *prospective* (future) coverage effective dates apply. This means that if an eligible enrollee chooses a plan within the special enrollment period and pays by the applicable special enrollment payment deadline, the coverage will be effective the first day of the following month. These categories include:

- **a)** *Gaining access to QHP because of a permanent move*:[37] If an individual gains access to a new QHP as a result of a move, the effective date of coverage is the first of the month following the move.
- **b)** *Following Death*:[38] HealthSource RI must ensure coverage for the surviving family members on the first day of the month following plan selection (HealthSource RI may also allow such enrollees or their dependents to select a standard enrollment effective date).

Example: A man moves to RI and selects a plan on August 8, during his special enrollment period. He pays by August 23rd, so his earliest coverage start date is September 1st. If he does not make the first month's payment until September 15 (after the August 23 deadline), his earliest coverage start date would be October 1.

2) Special Effective Coverage for Special Enrollment Effective Dates

[37] HealthSource RI policy deviates from 45 CFR 155.420(d)(7), under which the coverage start date is the first of the month following plan selection.
[38] 45 CFR 155.420(b)(2)(vi)

For certain qualifying events, the effective date of coverage may deviate from the general standard. The following is a list of qualifying events that entitle individuals to special enrollment periods with unique effective coverage dates:

- **a)** *Loss of Minimum Essential Coverage*:[39] For individuals who lose minimum essential coverage, including becoming ineligible for employer-sponsored insurance, the effective date is the first day of the month following loss of coverage.
- **b)** *Birth, Adoption, Placement for Adoption/Foster Care, Child Support Order/Court Order*:[40] Coverage is generally effective on the date of the birth, adoption or placement for adoption or foster care. However, HealthSource RI may also permit eligible individuals to begin coverage on the first day of the month following the qualifying event.
- **c)** *Marriage*:[41] HealthSource RI must ensure a coverage effective date for the enrollee on the first day of the month following the marriage.
- **d)** *Other Special Effective Dates*:[42] In the following situations, coverage effective dates are determined by HealthSource RI based on appropriate circumstances of the scenario, but special enrollment periods may never be longer than 60 days:[43]
    - **i.** The eligible individual's or dependent's enrollment (or non-enrollment) in a QHP is unintentional, inadvertent, or erroneous and is the result of an error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of HealthSource RI, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities;
    - **ii.** The enrollee or dependent adequately demonstrates to HealthSource RI that the QHP the individual is enrolled in substantially violated a material provision of its contract with the enrollee;
    - **iii.** The eligible individual, enrollee, or dependent, demonstrates to HealthSource RI, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as HealthSource RI may provide;
    - **iv.** HealthSource RI has determined that a qualified individual, enrollee, or dependent, was not enrolled in QHP coverage; was not enrolled in the QHP selected by the qualified individual or enrollee; or is eligible for but is not receiving advance payments of the premium tax credit or cost-sharing reductions as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities.

[39] HealthSource RI policy deviates from 45 CFR 155.420(b)(2)(iv), under which the coverage start date is the first of the month following plan selection.
[40] 45 CFR 155.420(b)(2)(i)
[41] HealthSource RI policy deviates from 45 CFR 155.420(b)(2), under which the coverage start date is the first of the month following plan selection.
[42] 45 CFR 155.420(b)(2)(iii)
[43] 45 CFR 155.420(c)(3)

Example: A child is born on July 24. Her parents complete her enrollment and pay their monthly premium on August 18. The effective date of coverage for the new baby would be July 24 and any APTC or CSR would be applied as of August 1. The parents could also choose to have August 1, or September 1 as the baby's coverage start date, with any APTCs/CSRs becoming effective on that day.
Example: A HealthSource RI customer gets married on November 20. She adds her new spouse to her plan on December 20 and pays the first month's premium on December 22. Her new spouse's effective date of coverage could be as early as December 1, because the special enrollment period arose due to a marriage.
Example: A Rhode Islander loses his health insurance on October 31. If he selects a plan and pays the current month's premium (as well as any outstanding prior months' premiums) during the 60 day special enrollment period, his effective date of coverage can be November 1, December 1 or January 1.

E. Request for Change to Coverage Start Date and Effectuation of Coverage

A customer may make a request to HSRI to change an enrollee's coverage start date for insurance. Customers may make this request if they feel HSRI made an error in processing their enrollment start date. These requests are handled on a case-by-case basis by the HSRI research team and all requests for these types of changes need to be made by calling the contact center.

Any request to update the start date of health coverage, if granted, will take up to 30 days to be reflected by the health insurance carrier. **Customers in this 30-day window who seek medical services may need to submit claims for reimbursement to their carrier**. Once the coverage date has been successfully updated at the carrier, customers will be able to submit any denied claims for reimbursement. Once a coverage start date has been moved to accommodate special requests, HSRI retains discretion to no longer fulfill future requests to move coverage start date further into the future.

The table below provides a summary of the effective dates for enrollment, special enrollment and the application of APTCs.

Table 1: Summary of Effective Dates for Enrollment, Special Enrollment and Effective Dates for APTCs

Category	Coverage Effective Dates Details
Regular Enrollment in QHP	A newly selected QHP is effective the 1st day of the next month if it is selected and payment is received by the 23rd day of the month, and the 1st day of the subsequent month if it is selected or paid for after the 23rd day of the month. For plans selected in the open enrollment period, typically November or December, payment must be received by the annual open enrollment deadline[44] for an effective date of January 1 in the upcoming coverage year.
APTC Effective Start Date	The start date of APTCs will be the first of the month following the effective date of coverage for the following special enrollment scenarios: • Birth • Adoption • Placement for adoption • Placement in foster care • Child support order/court order • Marriage • Loss of minimum essential coverage If the coverage start date for birth, adoption, or marriage falls on the first of the month, the APTC will be effective on that date. For all other special enrollment scenarios, the effective date of APTCs is the first day of QHP enrollment.
APTC Effective End Date	If eligibility has changed and APTCs have been discontinued, the effective end date for APTC discontinuance will be first day of the month following the date of the eligibility determination.
Special Enrollment: Birth, Adoption, Foster Care, Court Order	When a new dependent is added to the household as the result of birth or adoption, placement of adoption, placement in foster care, or as the result of a child support order/court order, at the election of the enrollee, the new household member may be enrolled in coverage retroactively effective the date of the birth, adoption, placement for adoption, placement in foster care, or as the result of a child support order/court order and the household is given the option to purchase a new QHP or remain on their current QHP; If there is an APTC change as a result of the birth or adoption, the APTC amount does not apply retroactively, but rather, it is effective on the first of the next month.
Special Enrollment: Marriage	When a new member is added to the household as the result of marriage to an existing member, the new household member is enrolled in coverage effective the 1st day of the month following the month in which the marriage occurred and both spouses are given the option to purchase a new QHP or remain in the current QHP.
Special Enrollment: Loss of Minimum Essential Coverage (MEC)	When a new member reports loss of MEC, the new household member is enrolled in coverage effective the 1st day of the month following the month in which the loss of MEC occurred.
Special Enrollment: American Indian	Special enrollment for QHPs is always open for American Indians from the 1st day of the month to the last day of the month. An American Indian/Alaskan Native may enroll in a QHP or change QHPs up to one time per month.

F. Automatic Renewal

An eligible individual/family enrolled in a QHP will receive notice prior to open enrollment indicating whether they will be automatically renewed in the same or a similar plan during the subsequent annual open enrollment period. If the customer will be automatically renewed, then the customer's notice will include the matched plan and estimated cost for the coverage household based on the previous year's application. Upon automatic renewal, coverage will be effective January 1st of the next year. Customers are strongly encouraged to review plans during the annual open enrollment period and enroll in a plan that is most in line with their coverage needs, as plan prices, plan benefits, and APTC eligible amounts may change from year to year. By actively reviewing plans on

[44] Again, the payment deadline is subject to change each annual enrollment period; see 220-RICR-90-00-1.6(C).

HealthSource RI, consumers will ensure that they are choosing the plan that is best suited to their needs. Even though a customer may be automatically renewed, they must still make payment in full by the relevant dates for coverage to be considered active on January 1st. If the customer misses the payment deadline for January, their application will be cancelled and they must resubmit their application prior to the end of open enrollment, select a new coverage start date, and make a timely payment for coverage to become active the next month.

Chapter 4: Eligibility for Advance Premium Tax Credits & Cost Sharing Reductions

A. Overview of Advance Premium Tax Credits and Cost Sharing Reductions

Premium tax credits and Cost Sharing Reductions (CSRs) are subsides made available by the federal government to help individuals and families pay for the cost of health insurance coverage purchased through HealthSource RI. To be eligible for a premium tax credit or CSR, an individual must:

- Be part of a household that files (or will file) taxes and meets financial eligibility standards; if married, household must file taxes jointly
- Enroll in a Qualified Health Plan (QHP) through HealthSource RI; and
- Be without access to an affordable alternative source of coverage that meets basic standards, i.e., "minimum essential coverage" (MEC).

A premium tax credit becomes available at the end of the tax year, when a household files its annual tax return and reports the coverage the household purchased during the preceding year.

A premium tax credit also may be paid in advance on a monthly basis to provide immediate financial assistance to households to help them purchase a QHP. When the tax credit is paid in advance, it is called an Advance Premium Tax Credit (APTC). For households eligible for APTCs, this assistance is sent to the insurance carrier on their behalf to offset each monthly bill. The amount of APTCs that the household receives will appear on monthly billing invoice sent by HealthSource RI.

This Chapter focuses on initial eligibility for APTCs and CSRs. Information on the redetermination of eligibility and enrollee obligations to report changes that occur throughout the year are not included in this Chapter, nor is information regarding the reconciliation process. For information on redeterminations of eligibility, please see Chapter 8. For more information about the reconciliation process, please see Chapter 5.

HealthSource RI is obligated to transmit individual market eligibility and enrollment information to the Federal government as necessary for the Federal government to begin, end, or change APTCs or CSRs.[45] HealthSource RI will transmit individual eligibility and enrollment information to the Carriers as necessary for them to calculate the amounts they should collect from the Federal government on behalf of covered individuals/households who qualify for APTCs and CSRs, including initial determinations, mid-year changes, and annual changes in eligibility.

1) Advance Premium Tax Credits

APTCs are available to households based on eligibility criteria, including household size and annual income, they are intended to help offset some of the cost associated with purchasing health insurance. To calculate a household's APTC eligibility, HealthSource RI will first identify the **second** lowest cost silver plan that is available in that policy year, called the "benchmark plan." The amount of tax credit the household is eligible for is equal to the total cost of the benchmark plan (or plans) that would cover the family, minus the household's expected

[45] as required by 45 C.F.R. § 155.340

contribution for coverage. The expected contribution is based on the Federal Poverty Level (FPL) and uses on a sliding scale; it varies from 2% of income for households at 100% of the FPL to 9.56% of income for those at 400% of the FPL.[46]

APTC eligible customers can use their APTCs to buy any category of health plan offered through HealthSource RI Their monthly payment may increase or decrease based on their plan selection.[47] After a customer enrolls in a plan and pays for the first month of coverage, the customer's health insurance company will start to directly apply the customer's APTCs to the customer's monthly health insurance bill. Households can apply tax credits toward the purchase of any available QHP sold through HealthSource RI except a catastrophic plan.[48]

2) Cost Sharing Reductions

Cost-sharing reductions (CSRs) are available to households who earn up to 250% of the FPL AND enroll in a silver-level QHP plan through HealthSource RI. CSRs are also available to American Indian and Alaska Native households who enroll in any level QHP (See "Eligibility for Cost Sharing Reductions, American Indian/Alaska Native Population"). CSRs are used to reduce the out-of-pocket costs of medical care such as deductibles, co-payments, and coinsurance for covered services. Similar to APTCs, the federal government sends CSR subsidies directly to health insurance companies on behalf of CSR-eligible households. There are three different levels of CSRs available, eligibility for each depending on a household's FPL.

B. APTC Eligibility

1) Overview of APTC Eligibility

a) Eligibility Criteria

Households are eligible for an APTC in a given coverage month if they:[49]

- Anticipate having an annual household income of 138% to 400% of the FPL[50] (with an exception for non-citizens with income below 138% of FPL who are lawfully present and ineligible for Medicaid due to immigration status).[51]
- Plan to file a federal tax return and, if married, plan to file a joint return.[52] Married same-sex couples must also plan to file jointly.
- Cannot be claimed as a dependent on someone else's tax return.[53]

[46] Revenue Procedure 2017-36
[47] If a household is eligible for APTCs in excess of the cost of the QHP in which they enroll, and a child or children under the age of 19 in that household enrolls in a stand-alone dental plan, then any amounts of the APTC in excess of the cost of the QHP, up to the cost of the EHB portion of the pediatric stand---alone dental plan, may be claimed as a premium tax credit at the end of the year, see 26 CFR 1.36B-3(k). HealthSource RI cannot apply advances on premium tax credits towards stand-alone dental coverage in these circumstances.
[48] 45 CFR 156.440
[49] 45 CFR 155.305(f); 26 CFR 1.36B--2
[50] The FPL level is updated annually by the Secretary of Health and Human Services. For purposes of APTC eligibility, use the most recently published FPL on the first day of the annual open enrollment period.
[51] 45 CFR 155.305(f)(2); § 1.36B-2(b)(5)
[52] 45 CFR 155.300(a), § 1.36B-2(b)(2)
[53] 26 CFR 1.36B-2(b)(2)(3). Even if the taxpayer who could claim the APTC applicant as a dependent is expected not to do so, the applicant still is ineligible for an APTC. An APTC cannot be provided to an individual for whom a dependent deduction is "allowable to another

- Meet other eligibility requirements to enroll in a QHP (See Chapter 1).

In any given month, individuals can qualify for an APTC on behalf of themselves and any eligible household members who:

- Enroll in a QHP,[54] and
- Lack access to other MEC, such as employer-based coverage, employer-based coverage through the SHOP Exchange, Medicare, Medicaid, or CHIP. (See "Minimum Essential Coverage" below.)

b) Treatment of Households in Which Some Individuals Are Not Eligible for an APTC

An individual who is not eligible to purchase a QHP can still receive an APTC for other household members.[55] For example, a father who is not lawfully residing in the United States or who is incarcerated (and therefore ineligible to purchase a QHP) may still receive an APTC on behalf of his wife and children if the wife and children meet eligibility requirements. If an individual is not applying for coverage for him or herself, he or she must still provide the income and household information required to evaluate eligibility for other household members.

c) Special Rule for Lawfully Present Individuals Below 100% of the FPL

In general, households must have income between 138% and 400% of the FPL to be eligible for an APTC.[56]. However, lawfully present immigrants who are ineligible for Medicaid based on their immigration status[57] and whose household income falls below 138% of the FPL still may be eligible for an APTC. Such individuals must be lawfully present and must meet all of the other APTC eligibility criteria that apply to individuals with income at or above 138% of the FPL.

2) Household Composition and Size

To determine whether an applicant meets the financial eligibility criteria for an APTC, HealthSource RI must "construct" the applicant's household, i.e., identify the members of the applicant's family who are considered part of the household for APTC purposes.[58] After the household is constructed, HealthSource RI determines the household's income and compares it to the FPL for a household of the appropriate size.

For APTC purposes, an applicant's household consists of the family members who will file taxes together. Specifically, a household includes individuals for whom a taxpayer may claim a deduction for a personal exemption,[59] including tax dependents even if they live outside the home for some period of time. For assessing Medicaid eligibility, the same household is generally used except when alternative relationship-based household rules apply (see Chapter 6).

In the case of a dispute between parents as to who is eligible to claim a child or children as tax dependents,

taxpayer."

[54] 26 CFR 1.36B-2(c). The enrollment must be as of the first day of the month; if an individual enrolls in a QHP in the middle of a month, he or she cannot receive an APTC for that month.

[55] 45 CFR 155.305(f); 26 CFR 1.36B-2

[56] 45 CFR 155.305(f)(2); 26 CFR 1.36B-2(b)(5)

[57] See DHS Medical Assistance Policy Manual, Technical Eligibility Requirements: 0304.05.15.05; https://www.policy.dhs.ri.gov/0300.htm#_Toc359220686

[58] 26CFR1.36B-1(d)

[59] 45 CFR 155.305(f)(ii); 26 CFR 1.36B-2

HealthSource RI will not provide any assistance nor make a determination. HealthSource RI will only accept a court order as proof of which parent is authorized to claim a child or children as tax dependents for purposes of determining a household's eligibility for APTCs or CSRs.

Example: Consider two adults who are divorced with a child. The mother and child live together and the father lives separately. The father claims a personal exemption deduction for the child, so the child is included in the father's taxpayer household for the purpose of determining eligibility for an APTC. The father's taxpayer household size is two: the father and the child. The child is *not* included in the mother's taxpayer household for determining eligibility for an APTC, even if the child lives with the mother. The mother has a taxpayer household size of one for the purpose of assessing eligibility for an APTC.

a) Situations in which Multiple Taxpayer Households Enroll in One QHP

Multiple-taxpayer households receiving separate APTCs may enroll together in one QHP.[60] For example, a 25-year old expecting to file taxes separately from her parents may choose to enroll in the same QHP as her parents. In this situation, the APTC is calculated separately for each taxpayer household, and both APTCs are applied to the same plan.

3) Household Income

In order to be eligible for an APTC, an applicant's projected annual household income must be between 138% of the FPL to 400% of the FPL[61] or, as explained below, less than 138% of the FPL for lawfully-present immigrants.[62] Household income is also included in the calculation to determine the total amount of a household's APTC (see section on "Formula for Calculating the Size of an APTC").

a) Whose Income is Counted

The income of all individuals in the taxpayer's household who are required to file taxes must be included in household income.[63] For example, a married couple with a teenage son who works part-time must include his income, but only if he earns enough income to require him to file taxes. For more information on who is required to file taxes, and what the appropriate tax filing thresholds are, see IRS Publication 501.[64]

Example: Consider a married couple expecting to file Federal taxes jointly who claim a personal exemption deduction for their 16-year old daughter. The QHP household size is three: the mother, father, and daughter. Both parents are employed and their daughter also earns $300 per year through babysitting jobs. When determining their household income, the parents' income is included, but the daughter's income is not included because her earned income is below the tax filing threshold. She is not required to file her own tax return. If, however, she anticipates taking on an additional job that would pay enough money to put her over the tax-filing threshold, she would be required to file her own tax form and her earnings would be included in the household's income.[65]

[60] 26 CFR 1.36B-3(h)
[61] 45 CFR 155.305(f)(i); 26 CFR 1.36B-2(b)
[62] 45 CFR 155.305(f)(B)(2)
[63] 45 CFR 155.305(f); 26 CFR 1.36B-1(e)
[64] IRS Publication 501 is available at: http://www.irs.gov/publications/p501/ar02.html#en_US_2012_publink1000220851
[65] 26 CFR 1.36B-1(e)(ii)(B)

b) Use of Projected Income

HealthSource RI applies a household's "projected" annual income to assess its eligibility for APTCs.[66] Projected annual income is the applicant's best estimate for the household's income during the year the applicant hopes to enroll in coverage. Projected income must be based upon reasonable and verifiable expectations (see Chapter 7), such as past year's income and expected changes to income based on factors such as a planned job change, a promotion, planned retirement, or expected re-entry into the work force. While HealthSource may assist customers with the math portion of estimating annual household income, HSRI are not tax professionals and customers are ultimately responsible for the projected annual income number that they report. Customers should consult with a tax professional if they have questions regarding how to best project their annual income.

Households which end up reporting a different amount of income for the year on their federal tax forms than they provided to the exchange for purposes of determining eligibility may either be responsible for repaying excess APTCs received to the IRS, or may be entitled to a refund for underpayments of APTCs for which the household was eligible. See Chapter 5 for additional information.

Example: A Rhode Island man loses his job in June and applies for coverage through HealthSource RI on July 1. To evaluate his eligibility for APTCs, HealthSource RI needs to calculate his expected income for the entire year, because APTCs are calculated based on an **annual** income. To do this, HealthSource RI will combine his earnings for the first half of the year while employed with any unemployment income he might have beginning in June for the rest of the year.

If he earned $20,000 during the first half of the year and expects to receive $10,000 in unemployment benefits through December 31, his projected annual income would be $30,000 ($20,000 for January through June plus $10,000 for July through December). HealthSource RI does NOT simply look at his expected income for the remainder of the year.

c) What Counts as Household Income

For calculating household income as it relates to assessing APTC eligibility, HealthSource RI uses a measure of income known as "Modified Adjusted Gross Income" or "MAGI."[67] MAGI is based on the IRS definition of what counts as income after selected deductions are taken into account. MAGI consists of the following types of income, as defined by the IRS:[68]

- **Adjusted Gross Income**

Adjusted gross income is gross income adjusted by "above-the-line" deductions.[69] For most tax payers, wages and salaries will constitute the majority of their gross income. However, as discussed in more detail below, gross income also includes income from a broad array of other sources, such as unemployment benefits, taxable interest, and capital gains. "Above-the-line" deductions refer to the adjustments that people can make to their gross income. These include alimony payments, interest on student loans, and other items that appear on page

[66] 45 CFR 155.305(f)(i); 26 CFR 1.36B-2(b)
[67] 26 CFR 1.36B-1(e)
[68] 26 CFR 1.36B-1(e)(2)
[69] 26 USC § 62

one of Form 1040. However, they do not include charitable contributions, mortgage interest and other "below-the-line" deductions.

- **Social Security Benefits Not Included in Adjusted Gross Income**

For federal income tax purposes, the federal government only taxes Social Security benefits for people who meet certain income criteria and, then, only a share of their benefits are taxed.[70] However, all Social Security benefits are included in MAGI, regardless of whether they are considered taxable or non-taxable income for federal tax purposes.

- **Tax-Exempt Interest**

Most of the interest that tax payers receive from bank accounts, money market accounts, certificates of deposit, and deposited insurance dividends is considered taxable income. However, interest on some bonds issued by, and used to finance, state and local government operations is not taxable at the federal level. This tax-exempt interest is considered as part of MAGI. [71]

- **Foreign Earned Income**

While foreign earned income generally is not subject to taxation, it is included in MAGI.[72] It is the income received from sources within a foreign country or countries that constitute earned income attributable to services performed by the individual when they were:

- A U.S. citizen and a bona fide resident of a foreign country for an uninterrupted period of time, which includes an entire taxable year; or
- A U.S. citizen or resident and who, during any period of 12 consecutive months, is present in a foreign country for at least 330 full days during that period.

d) Determining Modified Adjusted Gross Income (MAGI)

MAGI is rooted in the IRS definition of income developed to help tax payers file their annual returns. However, APTCs are based on a household's projected annual income during the month in which it is applying for coverage. HealthSource RI will assist households in generating their projected annual MAGI based on their circumstances at the time of application. In practice, there are two ways HealthSource RI can help applicants determine their household's projected annual MAGI: use of prior year's federal tax return or "construct" MAGI.

Both methods, described in more detail below, rely on identical IRS definitions of what constitutes income and allowable deductions. Using a prior year's tax return allows HealthSource RI to estimate based on the work that already has been done by the applicant to report his or her data and deductions in accordance with IRS rules. If the prior year's tax return is no longer relevant, HealthSource RI must help to construct the projected MAGI for the year in which the household is applying for an APTC or CSR using the same IRS definitions and rules.

[70] 26CFR1.36B-1(e)
[71] 26 CFR 1.36B-1(e); IRS-Income Received, available at: http://www.irs.gov/taxtopics/tc403.html
[72] 26 USC § 9

- **Use a Prior Year's Federal Tax Return**

This method requires pulling "adjusted gross income" off the appropriate line of the tax form and making a few additions, if applicable, for foreign earned income, tax-exempt interest, and any untaxed Social Security benefits. This method works if an applicant's circumstances haven't changed notably since the applicant's last tax filling.

The adjusted gross income amount can be found at:[73]

- IRS Form 1040EZ: Line 4
- IRS Form 1040A: Line 21
- IRS Form 1040: Line 37

If applicable, HealthSource RI will then add the following sources of income from the tax form to transform the household's "adjusted gross income" into "modified adjusted gross income":

- Any Social Security benefits not already included in adjusted gross income (Line 20a of IRS Form 1040).
- Foreign earned income excluded from gross income (include on Line 7 of IRS Form 1040 based on Line 26 of IRS Form 2555 or Line 17 of IRS Form 2555-EZ), and
- Tax-exempt interest the taxpayer expects to receive or accrue during the year (Line 8b of last year's Federal tax return IRS Form 1040).

- **"Construct" MAGI**

When a household has experienced a substantial change in circumstances since filing its tax return (or anticipates such a change will occur during the current calendar year), HealthSource RI will help the household "construct" its projected annual modified adjusted gross income. This method requires gathering detailed information on an applicant's income from various sources, and adjusting that income to take into account the "above-the-line" deductions. As a first step, HealthSource RI will determine the household's gross income. The types of income that count and do not count are identified in Table 1 below.[74]

Table 1. Examples of What Income Counts & Does Not Count Under MAGI[75]

Income that counts towards MAGI

[73] For federal tax purposes, "above-the-line" deductions can only be used by individuals who file a Form 1040 or Form 1040A. They cannot be claimed by someone who relies on the Form 1040EZ because the form is not designed to capture them. In the context of APTC eligibility, however, the deductions are available to all households who are not relying on their prior year federal tax form as the sole basis for establishing their projected annual household income.

[74] For additional information on adjusted gross income, see IRS Publication 17, available at: http://www.irs.gov/publications/p17/. For IRS income types, please visit: http://www.irs.gov/taxtopics/tc400.html.

[75] For additional information, please refer to 26 USC 61. The list presented here is based on the Centers for Medicare and Medicaid Services' description of the types of income that count toward "gross income" for purposes of MAGI. See also Centers for Medicare & Medicaid Services Single Streamlined Application, Attachment A: List of Items in the Online Application to Support Eligibility Determinations for Enrollment through the Health Insurance Marketplace and for Medicaid and the Children's Health Insurance Program.

Taxable wages/salary (before taxes are taken out) *Note that pre-tax contributions to dependent care accounts, health insurance premiums, flexible spending accounts, retirement accounts and commuter expenses are NOT included as*
Self-employment (profit once business expenses are paid)[77]
Social Security benefits
Unemployment benefits
Alimony received
Most retirement benefits
Interest (including tax-exempt interest)
Net capital gains (profit after subtracting capital losses)
Most investment income, such as interest and dividends
Rental or royalty income (profit after subtracting costs)
Other taxable income, such as canceled debts, court awards, jury duty pay not given to an employer, cash support, and gambling, prizes, or awards
Foreign earned income
Income that does NOT count
Child support received
Supplemental Security Income (SSI)
Worker's compensation payments
Veterans benefits
Gifts

a. Accounting for "Above-the-Line" Income Deductions

As a second step, an applicant's gross income must be adjusted by the above-the-line deductions discussed above.[78] Some of the tax deductions include:

- Certain self-employment business expenses
- Portion of interest on student loans
- Alimony paid
- Most contributions to retirement accounts[79]
- Tuition and fees[80]
- Health savings account contributions[81]
- Penalties on the early withdrawal of savings[82]
- Educator expenses[83]
- Moving expenses related to a job change[84]

[76] Czajka, John. May 2013. Translating Modified Adjusted Gross Income (MAGI) to Current Monthly Income. State Health Access Reform Evaluation. Available at: http://www.shadac.org/files/shadac/publications/TranslatingMAGItoCurrenlyMonthlyIncome.pdf.
[77] 26 USC 1402
[78] A comprehensive list of these deductions can be found at: http://www.law.cornell.edu/uscode/text/26/62 with additional information at the IRS website at http://www.irs.gov/Credits---&---Deductions.
[79] 26 USC § 219.
[80] 26 USC § 222.
[81] 26 USC § 223.
[82] 26 USC § 165.
[83] 26 USC § 162.
[84] 26 USC § 217.

- Certain business expenses of performing artists, reservists, and fee-basis government officials[85]

The above-the-line deductions potentially most common among low- and moderate-income households include certain self-employment expenses, most contributions to retirement accounts, alimony paid, tuition and student fees, and a portion of student loan interest.[86]

b. Deductions for Certain Self-Employment Expenses

Most deductions for self-employed business expenses are included in net income (the profit once business expenses are paid), but additional deductions can be taken for the deductible part of self-employment tax,[87] self-employed SEP, SIMPLE, qualified plans,[88] and self-employed health insurance deductions.[89,90]

c. Alimony Payment

Alimony is a payment to a spouse or former spouse under a divorce or separation agreement.[91]

d. Portion of Student Loan Interest

Households may be able to deduct a portion of the interest they expect to pay on a qualified student loan.[92] Box 1 of the 1098-E Form shows the interest paid for the prior year, which may be helpful in projecting student loan interest that will be paid during the year.

e) Comparing Household Income to the Federal Poverty Level

To assess financial eligibility for APTCs, HealthSource RI will compare a household's projected annual income to the FPL guidelines for the appropriate household size.[93] HealthSource RI will use the most recently published FPL guidelines available as of the first day of the annual open enrollment period for coverage by a QHP offered through HealthSource RI for a calendar year.[94,95]

The FPL used to determine APTC eligibility may be different than the FPL used for Medicaid eligibility. Medicaid uses FPL levels in accordance with the rules set forth by their agency (see Chapter 6).[96]

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[85] 26 USC § 162.
[86] Czajka, John. May 2013. Translating Modified Adjusted Gross Income (MAGI) to Current Monthly Income. State Health Access Reform Evaluation. Available at: http://www.shadac.org/files/shadac/publications/TranslatingMAGItoCurrenlyMonthlyIncome.pdf.
[87] IRS Self-Employment Tax. http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Self-Employment-Tax-Social-Security-and-Medicare-Taxes
[88] IRS Self-Employment Tax. http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Self-Employment-Tax-Social-Security-and-Medicare-Taxes
[89] 26 USC § 162.
[90] For additional information see IRS Publication 334, Tax Guide for Small Business.
[91] 26 USC 215; IRS-Alimony Paid, available at: http://www.irs.gov/taxtopics/tc452.html.
[92] 26 USC § 221; IRS---Student Loan Interest Deduction, available at: http://www.irs.gov/taxtopics/tc456.html.
[93] The FPL level is updated annually by the Secretary of Health and Human Services.
[94] 45 CFR 155.300(a)
[95] The initial open enrollment extended from October 1, 2013 through March 31, 2014, which meant the 2013 FPL levels were used for the initial open enrollment period. For the 2015 coverage year, the annual open enrollment period extended from November 15 to February 15, and 2014 FPL levels were used. In subsequent years, the open enrollment period will extend from October 1 through December 15.
[96] 42 CFR 435.4

4) Ineligibility Based on Access to Minimum Essential Coverage

In general, people are ineligible for an APTC if they have sufficient income to secure adequate coverage (i.e., "minimum essential coverage" or MEC) through a source other than HealthSource RI.[97] This federal requirement is designed to reserve the availability of APTCs to households who do not have alternative affordable coverage options through their jobs, government programs, or other sources.

a) Definition of MEC for Purposes of APTC Eligibility[98]

For purposes of APTC eligibility, the term "minimum essential coverage" (MEC) means coverage under any of the following:

- Most government-sponsored insurance,
- Eligible employer-sponsored insurance,
- Grandfathered health plans,[99] and
- Other coverage that is recognized as MEC by the Secretary of Health and Human Services, including foreign health coverage and self-funded student health coverage.

Some types of very limited coverage are not considered "MEC". These "excepted benefits" policies include the following:[100]

- Accidental death and dismemberment coverage
- Disability insurance
- General liability insurance
- Automobile liability insurance
- Workers' compensation
- Credit-only insurance (e.g. mortgage insurance)
- Coverage for employer-provided on-site medical clinics
- Limited-scope dental or vision benefits
- Long-term care benefits
- Benefits provided under most health flexible spending arrangements
- Policies that cover only a specified disease or illness (e.g. cancer-only policies)
- Supplemental coverage, such as Medicare supplemental policies, TRICARE supplemental policies, and similar supplemental coverage to coverage under a group health plan.

b) Government-Sponsored MEC

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[97] 45 CFR 155.305(f), 26 CFR 1.36B---2(c)

[98] 26 USC 5000A(f); Proposed 26 CFR 1.5000A-2; Proposed 45 CFR 156.602. Note that the concept of MEC also is used to determine who may be exempt from a shared responsibility payment. For this purpose, the list of coverage that constitutes MEC is slightly different as discussed in Chapter X.

[99] A grandfathered health plan is a group health plan or group health insurance coverage that was already in existence on March 23, 2010, when the Affordable Care Act was signed into law. Grandfathered status excludes plans from certain mandates under the law (ACA Section 1251; Proposed 26 CFR 1.5000A-2(e)).

[100] 26 USC 5000A(f)(3)

A household is considered eligible for government-sponsored MEC - and therefore ineligible for an APTC - if it meets the eligibility criteria for coverage under the programs listed below.[101] Unless otherwise noted, it is eligibility for the program – not actual enrollment in it – that makes a household member ineligible for an APTC. Government-sponsored MEC includes the following coverage:[102]

- Enrolled in Medicare Part A not requiring paying a Part A premium[103] (most Medicare beneficiaries do not need to pay Part A premiums and are automatically considered eligible for MEC)
- Medicare Advantage plans (Medicare Part C),
- Medicaid, **other than** for:
    - Optional coverage of family planning services
    - Optional coverage of tuberculosis-related services
    - Coverage of pregnancy-related services
    - Coverage of emergency medical services
- CHIP[104]
- Enrolled in TRICARE
- Enrolled in veterans' health coverage[105]
- Peace Corps volunteer program
- Refugee medical assistance supported by the Administration for Children and Families
- Enrolled in a student health plan[106]
- Enrolled in State high risk pool coverage[107]

i) Time of Eligibility

An individual is treated as eligible for a government-sponsored program on the first day of the first full month in which he or she may actually begin receiving benefits under the program.[108] This means that an individual is **not** treated as eligible for a government-sponsored program (and therefore **is** eligible to receive APTCs) during:

- The time required for application processing (i.e., the period of time between application submission and approval), and
- Any interim period between when a person is found eligible for a government- sponsored program and the date

[101] 26 CFR 1.36B-2(c)(2)(i)
[102] 26 CFR 5000A(f)(1); 26 CFR 1.36B-2(c)(2)(i); Proposed 26 CFR 1.5000A-2(b); Proposed 45 CFR 156.602
[103] Proposed IRS Notice 2013-41, issued on June 26, 2013. Available at: http://op.bna.com/dt.nsf/id/sdoe--992kz2/$File/Notice%202013-41.pdf.
[104] Children age one and above who lose CHIP coverage due to a failure to pay premiums and who may not re-enroll in CHIP for four months are treated as eligible for CHIP and do not qualify for an APTC during that time period.
[105] The veterans' health coverage programs that represent MEC for those who are enrolled include the medical benefits package authorized for eligible veterans under 38 U.S.C. 1710 and 38 U.S.C. 1705; the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) authorized under 38 U.S.C. 1781; comprehensive health care program authorized under 38 U.S.C. 1803 and 38 U.S.C. 1821 for certain children of Vietnam Veterans and Veterans of covered service in Korea who are suffering from spinal bifida; and the Non-appropriated Fund Health Benefits Program of the Department of Defense (*Proposed 26 U.S.C. 1.5000A---2(b)(5) and (7))*.
[106] Proposed IRS Notice 2013-41, issued on June 26, 2013. Available at: http://www.irs.gov/pub/irs-drop/n-13-41.pdf
[107] The proposed rule designates state high-risk pools as MEC subject to further review by the Secretary (*Proposed 45 CFR 156.602(e)*). HHS specifically notes that it "reserves the right to review and monitor the extent and quality of coverage, and in the future to reassess whether they should be designated minimum essential coverage or should be required to go through the same [designation] process outlined in 156.604" of the proposed rule (*Preamble 7361*). The proposed IRS notice 2013-41 issued on June 26, 2013 states that individuals are eligible for MEC for purposes of APTC eligibility if they are enrolled in high-risk pool coverage. Available at: http://www.irs.gov/pub/irs---drop/n-13-41.pdf
[108] 26 CFR 1.36B-2(c)(2)(i)

when he or she can begin receiving benefits (i.e., the period of time between application approval and the effective date of coverage).

Example: Consider a taxpayer who applies for coverage under a government-sponsored health care program. The individual's application is approved on July 12, but her coverage is not available until September 1. The individual is considered eligible for government-sponsored MEC on September 1 [109] and if meeting all other applicable criteria for APTC, would be considered APTC eligible through August 31.

ii) Obligation to Complete Administrative Requirements to Obtain Coverage

Individuals eligible for a government-sponsored program, but who do not apply for such coverage, are still excluded from APTC eligibility after they have exceeded the deadline to apply for coverage (with the exception discussed below for people eligible for veterans health coverage programs or for certain individuals eligible but not enrolled for Medicare Part A). Individuals who meet the eligibility criteria for a government-sponsored program are expected to apply by the last day of the third full calendar month following the event that establishes their eligibility, such as loss of a job that makes the individual eligible for Medicaid.[110] If they do not apply by that date, they nevertheless will be treated as eligible for MEC (and thereby ineligible to receive APTCs) beginning on the first day of the fourth calendar month following the qualifying event.[111]

Example: Consider an individual who turns 65 on June 3, and becomes eligible for Medicare. In compliance with requirements necessary to receive benefits, the individual enrolls in Medicare in September, the last month of his initial enrollment period, and is able to receive Medicare benefits beginning on December 1. Because he completed necessary requirements by the last day of the third full calendar month after the event that established his eligibility (i.e., turning 65), the individual is treated as eligible for government-sponsored MEC on December 1 (the first full month he may receive benefits under the program).[112]

Example: Consider the same scenario, except that the individual fails to enroll in the Medicare coverage during his initial enrollment period. In this instance, the individual is treated as eligible for government-sponsored MEC as of October 1, 2015 (the first day of the fourth calendar month following the event that established his eligibility).[113]

iii) Special Rule for Veterans Coverage Programs

An individual is treated as eligible for MEC through a veterans health care program under Chapter 17 or 18 of Title 38, U.S.C. only if the individual is actually enrolled in the program.[114]

iv) Retroactive Eligibility

[109] 26 CFR 1.36B-2(c)(2)(vi)
[110] 26 CFR 1.36B-2(c)(2)(ii)
[111] 26 CFR 1.36B-2(c)(2)(ii)
[112] 26 CFR 1.36B-2(c)(2)(vi)
[113] 26 CFR 1.36B-2(c)(2)(vi)
[114] 26 CFR 1.36B-2(c)(2)(iii)

Retroactive eligibility means eligibility covering a period of time in the past. If an individual is determined to be eligible for government-sponsored MEC on a retroactive basis (such as Medicaid), this does not affect his or her eligibility for APTC during the retroactive period. Individuals found eligible for Medicaid are only excluded from APTC eligibility on a prospective basis. They will be treated as eligible for MEC no earlier than the first day of the first calendar month beginning after the approval of the Medicaid application, as discussed above.[115]

Example: Consider an individual who in November enrolls in a QHP for the upcoming coverage year and receives APTCs to help pay for the cost of the plan. Subsequently, the individual loses her part-time employment and on April 10 applies for coverage under the Medicaid program. Her application is approved on May 15, and her Medicaid coverage is effective as of April 1. The individual is treated as eligible for government-sponsored MEC on June 1.[116]

v) Failure to Reconcile

An enrollee shall not be eligible for APTCs if:[117]

(1) Enrollee (and spouse, if applicable) did not comply with the requirement to file an income tax return for the prior year(s), as required by Sections 6011 and 6012 of IRC (26 USC §§ 6011, 6012) and implementing regulations; or
(2) The APTC was not reconciled for that period.

The HealthSource RI application includes a tax filing related question. This question will display on all applications and allow enrollees who received APTCs for the prior year to attest, under the penalty of perjury, to having filed their tax return for the applicable prior year and reconciling their APTCs.

After filing and reconciling the applicable prior year's APTCs, attesting to having filed a tax return on the application will allow the enrollee to maintain eligibility for APTC even if IRS' data has not yet been updated. Enrollee's whose IRS data has not been updated but have filed a tax return and reconciled APTCs for the prior year must attest to having filed and reconciled on the application and select a plan by December 15 in order to maintain APTC eligibility for coverage effective January 1.

c) Employer-sponsored MEC

An individual who may enroll in an eligible employer-sponsored plan, either as an employee or as an individual who may enroll in the plan because of a relationship to an employee (i.e., a "related individual"), is treated as eligible for employer-sponsored MEC if the plan is:

- "Affordable"[118] and
- Provides "minimum value"(MV).[119]

[115] 26 CFR 1.36B-2(c)(2)(iv)
[116] 26 CFR 1.36B-2(c)(2)(vi)
[117] 45 CFR 155.305(f)(4); 26 U.S.C. 6011, 6012.
[118] 26 CFR 1.36B-2(c)(3)(i)
[119] 26 CFR 1.36B-2(c)(3)(i)

Employer-sponsored coverage includes coverage offered by a small business through the SHOP.

As described in more detail below, an eligible employer-sponsored plan is considered affordable for an individual if the annual premium she must pay to purchase coverage for herself does not exceed a specified percentage of household income.[120] A plan is considered to provide minimum value (MV) only if the plan's share of the total allowed costs of benefits provided to the employee and related individuals is at least 60% of such costs.[121]

i) Affordable Coverage

An eligible employer-sponsored plan is considered "affordable" for an employee if the portion of the annual premium he or she must pay for self-only coverage is less than a certain percentage of their household income. Each year, the required contribution percentage will be adjusted by the federal government to reflect growth in health care costs relative to other measures of economic growth and inflation.[122,123] The calculation of affordability for an employee's household members does not take into account the cost of providing household-based insurance. The "affordability" of employer-based insurance for related individuals is based **solely** on the cost of coverage for the **employee only**.

Example: Consider a woman who in 2016 has a household income of $47,000. Her employer offers a health insurance plan that requires a contribution of $3,450 for self-only coverage for 2016 (which represents 7.3% of her household income). Because her required contribution for self-only coverage does not exceed 9.56% of household income, the plan is considered affordable and the individual is treated as eligible for employer-sponsored MEC for all months in 2016.

Example: Consider the same scenario, except that in this case she is married and her employer offers dependent coverage. Her required contribution to purchase coverage for her household (which includes herself, her husband and their child) was $8,250 (representing 17.5% of her household income). Because the cost of purchasing coverage for her family is not taken into account in the affordability test and her required contribution for self-only coverage does not exceed 9.56% of household income, **the plan is still considered affordable**. Accordingly, the individual is determined to have a source of affordable employer-sponsored coverage, and thus ineligible to receive APTCs on behalf of herself and/or members of her household.

- **Treatment of Wellness Incentives and Employer Contributions to Health Reimbursement Arrangement (HRA) in Determining Affordability**

With the exception of wellness programs designed to prevent or reduce tobacco use, non-discriminatory wellness program incentives offered by an eligible employer-sponsored plan that affect premiums **will not** be treated as increasing the affordability of coverage (i.e., affordability will be determined assuming that the employee fails to satisfy the requirements of the wellness program). In circumstances involving tobacco cessation wellness programs, the affordability of plans for tobacco users will be determined based on the

[120] 26 CFR 1.36B-2(c)(3)(v)(A)
[121] 26 CFR 1.36B-2(c)(3)(vi)
[122] 26 CFR 1.36B-2(c)(3)(v)(A)
[123] For plan years beginning in 2018, the affordability percentage is 9.56%

premiums charged to those users who complete a tobacco program (i.e., affordability will be determined assuming that the employee satisfies the requirements of the wellness program).[124] See Table 2 below.

Example: Consider an employer that offers an eligible employer-sponsored plan with a non-discriminatory wellness program that reduces premiums by $300 for employees who do not use tobacco products or who complete a smoking cessation course. Premiums are reduced by $200 if an employee completes cholesterol screening within the first six months of the plan year. One employee (Employee A) does not use tobacco and the cost of his premiums is $3,700. Another employee (Employee B) uses tobacco and the cost of her premiums is $4,000. Only the incentives related to tobacco use are counted toward the premium used to determine the affordability of the employer's plan. Accordingly, Employee B is treated as having earned the $300 incentive for attending a smoking cessation course. Thus, the employee's required contribution to premium for determining affordability for both Employees A and B is $3,700. The $200 incentive for completing the cholesterol screening is disregarded.[125]

Amounts made newly available under an HRA that is integrated with an employer-sponsored plan **can** be taken into account to determine affordability (i.e., can be considered as available to increase the affordability of employee coverage) provided that employees can use the amounts only for premiums, or for either premiums or cost sharing.[126]

Because Health Savings Account (HSA) funds typically cannot be used to pay insurance premiums, these amounts do not affect the determination of affordability. See Table 2 below.

Table 2. Treatment of Wellness Incentives & Employer Contributions to HRA in Determining Affordability

Applicability of Incentive/Amount to Premiums In Order to Determine Affordability	
Wellness Program – Non-Tobacco Cessation	No. Affordability determined assuming employee fails to earn incentive/complete program.
Wellness Program – Tobacco Cessation	Yes. Affordability determined assuming employee earns incentive/completes program.
Employer HSA Contribution	No. HSA funds generally cannot be used to pay premiums.
HRA Contribution	Yes, provided that employee can use HRA amounts to (1) reduce premiums or (2) for either reducing premiums or cost-sharing.

ii) Minimum Value and Methods for Determining MV

An eligible employer-sponsored plan provides MV only if the plan's share of the total allowed costs of benefits provided to the employee under the plan (as determined by HHS) is at least 60%.[127] The MV of a specific eligible employer-sponsored plan is calculated by dividing the anticipated covered medical spending for EHB coverage for the population covered by a

[124] 26 CFR 1.36B-2(c)(3)(v)(A)(4)
[125] 26 CFR 1.36B-2(c)(3)(v)(D)
[126] 26 CFR 1.36B-2(c)(3)(v)(A)(5)
[127] 26 CFR 1.36B-2(c)(3)(vi)

typical self-insured group health plan. This is computed in accordance with the specific group health plan's cost sharing by the total anticipated allowed charges for EHB coverage for a typical self-insured group health plan population.[128]

Table 3. Calculation of Minimum Value (MV)

Minimum Value equals:

$$\frac{\text{Anticipated EHB Costs Reimbursed by Plan}}{\text{Anticipated EHB Costs Covered by "Standard" Self-Insured Plan}}$$

Any one of the following methods can be used to determine whether an eligible employer-sponsored plan provides MV, [129] including use of:

- The MV Calculator made available by HHS and IRS on the HHS website;[130]
- One of the safe harbor plan designs established by HHS and IRS and described below; or
- For non-standard plans, actuarial certification from a member of the American Academy of Actuaries.

Plans in the small group market also meet MV requirements if they provide a bronze level plan.[131]

Individuals seeking advice as to whether the employer-sponsored insurance available to them meets the MV standard should seek guidance from their employer and/or insurance carrier.

Safe Harbors for Determining MV[132]

As an alternative to using the MV Calculator, an employer-sponsored plan could use one of three design-based safe harbors published by HHS and the IRS in the form of checklists to determine whether the plan provides MV. These include:

- A plan with a $3,500 integrated medical and drug deductible, 80% plan cost-sharing and a $6,000 maximum out-of-pocket limit;
- A plan with a $4,500 integrated medical and drug deductible, 70% plan cost-sharing, a $6,400 maximum out-of-pocket limit and a $500 employer contribution to an HSA; or
- A plan with a $3,500 medical deductible, $0 drug deductible, 60% medical cost sharing, 75% drug cost-sharing, a $6,400 maximum out-of-pocket limit, $10/$20/$50 copay tiered drug plan, and a 75% coinsurance for specialty drugs.

A summary of this information is in the following Table 4.

Table 4: Safe Harbors for Determining Minimum Value

[128] Proposed 26 CFR 1.36B-6(c)(1)

[129] 26 CFR 1.36B-6(d)
[130] The calculator is available at the following web site as of July 2013: http://www.cms.gov/cciio/Resources/Regulations-and-Guidance/index.html.
[131] 26 CFR 1.36B-6(d)(4)
[132] 26 CFR 1.36B-6(d)

Individual Out---of-Pocket Limit	Individual Deductible		Coinsurance	Prescription Drug Copayments	Employer Individual Annual HSA Contribution
	Medical	*Prescription Drug*			
$6,000	$3,500 integrated medical and drug		80% of all services	N/A	N/A
$6,400	$4,500 integrated medical and drug		70% of all services	N/A	$500
$6,400	$3,500	$0	60% medical 75% drug	$10/$20/$50 Specialty drugs at 75%	N/A

Treatment of Wellness Incentives and Employer Contributions to HRAs and Health Savings Accounts (HSAs) in Calculating MV

In some instances, wellness programs and employer contributions to HRAs and HSAs may be taken into account when determining a plan's MV percentage. See Appendix A for details on related requirements.

iii) Treatment of Open Enrollment Periods and Special Enrollment Periods

As with government programs, people are excluded from APTC eligibility if they could enroll in an employer-sponsored plan that meets affordability and minimum value criteria, regardless of whether or not they actually do so. As a result, people must be treated as eligible for employer-sponsored MEC for any months in a plan year during which they could have enrolled via an open or special enrollment period[133] (See Chapter 3 for information on special enrollment periods.) It is important to note that people will not be treated as eligible for employer-sponsored MEC during any required waiting period before the coverage becomes effective.[134]

Example: Consider an individual whose employer offers its employees a health insurance plan that has a plan year from October 1 through September 30. Employees may enroll during an open season from August 1 to September 15. In this scenario, the employee chooses not to enroll in the employer's plan for the October 1, 2014 – September 30, 2015 plan year and, in November 2014, she enrolls in a QHP through HealthSource RI for calendar year 2015. Because she could have enrolled in her employer's plan during the August 1 to September 15 open enrollment period, unless the plan is not affordable or does not provide minimum value, this individual is treated as eligible for employer-sponsored MEC for those months that she is enrolled in the QHP during her employer's plan year (i.e., from January through September 2015). [135]

iv) Continuation Coverage (e.g., COBRA)

An individual who may enroll in continuation coverage required under Federal (e.g., COBRA) or State law that provides comparable continuation coverage is treated as eligible for employer-sponsored MEC only for months that the individual is actually enrolled in the coverage.[136] If someone is provided with an offer to sign up for COBRA coverage, but opts not

[133] 26 CFR 1.36B-2(c)(3)(iii)
[134] 26 CFR 1.36B-2(c)(3)(iii)
[135] 26 CFR 1.36B-2(c)(3)(iii)(C)
[136] 26 CFR 1.36B-2(c)(3)(iv)

to do so, this does not adversely affect his or her potential eligibility for an APTC.

v) Enrollment in an Eligible Employer-Sponsored Plan

If a person is enrolled in employer-based coverage, it is deemed to be MEC regardless of whether it meets the affordability and minimum value standards.[137] However, for instances in which an employee is automatically enrolled in an employer-sponsored plan, the employee will be treated as not enrolled in the plan if he/she terminates coverage before the later of either: (1) the second full calendar month of that plan year or other period of automatic renewal; or (2) the last day of any permissible opt-out period provided by the employer-sponsored plan or in regulations to be issued by the Department of Labor.[138]

Example: Consider an individual whose required contribution for self---only employer coverage exceeded 9.56% of her 2014 projected annual household income. The individual enrolls in her employer's calendar year plan for 2014. The individual was treated as eligible for MEC for 2014 because she was enrolled in an eligible employer-sponsored plan for 2014.[139]
Example: Consider the same scenario, except that now the individual's employer automatically enrolled her in the plan for calendar year 2015. The individual terminates this coverage on January 20, 2015. The individual is treated as not eligible for MEC under her employer's plan for January 2015.[140]

d) Related Individual Not Claimed as a Personal Exemption Deduction

If an individual who may enroll in MEC due to a relationship to another person who is eligible for coverage (e.g., a child of a parent whose employer offers family coverage) is claimed as a dependent on the tax form of the person with primary access to the coverage, the related individual is treated as eligible for MEC regardless of whether he or she is actually enrolled in the coverage. However, if the related individual is **not** claimed as a dependent on the tax form of the person with primary access to the coverage, he or she will be treated as eligible for MEC under such coverage only for months in which the related individual is actually enrolled.

Example: Consider parents of a 25-year old daughter. If the parents expect to claim a personal exemption deduction for her, she is treated as eligible for MEC through her parent's employer-sponsored coverage (assuming it is affordable and meets minimum value). However, if the parents do not expect to claim a personal exemption for her, she would be treated as eligible for employer-sponsored MEC only for any months during which she is actually enrolled in her parents' plan. Thus, if she chooses to purchase coverage on her own via HealthSource RI, she is potentially eligible for an APTC (i.e., she is not excluded based on having minimum essential coverage through her parents, but she still must meet the other eligibility criteria for an APTC).

C. Calculation of APTC

1) Overview of APTC Calculation

[137] 26 CFR 1.36B-2(c)(3)(vii)(A)
[138] 26 CFR 1.36B-2(c)(3)(vii)(B)
[139] 26 CFR 1.36B-2(c)(3)(vii)(C)
[140] 26 CFR 1.36B-2(c)(3)(vii)(C)

The concept behind the APTC calculation is that households below 400% FPL are expected to contribute a limited share of their income toward purchasing a QHP. The share varies from 2% of income for households at 100% FPL to 9.56% of income for those at 400% FPL.[141] After they contribute this amount, the APTC "fills the gap" and provides enough of a subsidy that the household can afford to purchase the second lowest cost silver-level QHP or "benchmark plan" (described below).

A household may use the APTC to a buy a QHP that is more or less expensive than the benchmark plan. If someone buys a more expensive plan, the person must contribute more of his or her own funds toward the cost of coverage. If the person buys a less expensive plan, the APTC will cover a greater share of the cost of the plan. Under no circumstances, however, may a household receive an APTC that exceeds the actual cost of the coverage that is purchased.

The APTC is based on the cost of purchasing essential health benefits and it is only for such benefits. It cannot be used to subsidize additional benefits. (See "Treatment of Non-Essential Health Benefits below.)

2) Formula for Calculating the Size of an APTC

The size of a taxpayer's APTC is calculated by taking the amount a household must spend to purchase the silver-level plan for eligible household members and subtracting the amount that the household is expected to contribute toward its own health insurance ("contribution amount").[142] The remaining amount – or the gap between the cost of the benchmark plan and the household's contribution amount – determines the maximum APTC that a person may receive.

3) Actual Monthly Premium Costs Paid for QHP(s)

When an individual files taxes, the Internal Revenue Service reconciles the amount of APTC that the person received with the amount he is eligible to receive based on his tax return information.[143] Please see Chapter 5 for a further discussion of the reconciliation process.

a) Cost of the "Benchmark Plan"

The cost of the "adjusted premium for the applicable benchmark plan" (referred to in this document as the "benchmark plan") is based on the Second Lowest Cost Silver Plan (SLCSP) offered through HealthSource RI that can be used to cover the household members who are enrolling in a QHP.[144] In situations where some household members are enrolling in a QHP through HealthSource RI and other household members are either enrolling in Medicaid or are not enrolling in any coverage, the SLCSP is based only on the household members who are APTC-eligible and enrolling in a QHP.

Example: Consider a household with two parents and two children with projected annual household income of 210% FPL. The children are eligible for Medicaid and the parents are eligible for a QHP and APTCs on

[141] ACA Sec. 1401/Sec. 36B (b); 26 CFR 1.36B-3(g)
[142] 26CFR1.36B-3(d)
[143] 26CFR1.36B-4
[144] 26CFR1.36B-3(e)

HealthSource RI. The cost of covering the children is *not* included in calculation of APTC eligibility.

i) Treatment of Families that Need More than One QHP to Cover All Members[145]

If a single plan is not available that can cover an applicant's entire household, then the benchmark plan is based on the cost of the multiple plans it would require to cover all eligible household members. These must be reviewed on a case-by-case basis and be handled by calling the contact center.

Example: Consider a household consisting of a woman taking care of her disabled aunt. If she expects to claim her aunt as a dependent on her Federal tax return then she is eligible to receive an APTC on her aunt's behalf. If there is no QHP available that will allow the woman to enroll in a single family plan that covers both her and her aunt, HealthSource RI must combine the cost of the benchmark plan available to the woman as a single adult, and the benchmark plan available to her aunt as a single adult, to determine the cost of the benchmark plan.

b) Contribution Amount

The contribution amount is the amount a household is expected to contribute toward the cost of the benchmark plan. It is determined by a formula delineated in the ACA.[146]

Table 6. Premium Contribution Applicable Percentage by Income for 2016

% of Federal Poverty Line	Premium Contribution	Premium Contribution Final Percentage
Less than 133%	2.01%	2.01%
133-150%	3.02%	4.03%
150-200%	4.03%	6.34%
200-250%	6.34%	8.10%
250-300%	8.10%	9.56%
300-400%	9.56%	9.56%

c) Special Expected Contribution Rules for Households with Members who are not Lawfully Present

The ACA adjusts the expected contribution of households with members who are not lawfully present to reflect that some members are ineligible for enrollment in QHPs, as well as for APTCs.[147] In effect, the adjustments lower the expected contribution of such households because not all of their members can be enrolled in a QHP.

d) Actual Premium Costs

[145] 26 CFR 1.36B-3(f)(ii)(2)
[146] 26 CFR 1.36B-3(g)

[147] 26 CFR 1.36B-2; 26 CFR 1.36B-3

The amount of APTC that a household is eligible for in any given month cannot exceed the total monthly premium price of the coverage in which the eligible household members are enrolled.[148] QHPs may have a non-essential health benefit (EHB) portion of the premium that is not eligible for a premium tax credit. In other words, the APTC cannot be used to cover certain health benefits that do not fall within the ACA's definition of EHB, however some plans have a $0 non-EHB benefit.

Example: Consider a household that qualifies for a $1,000 APTC, but elects to purchase a very inexpensive bronze plan for $800 a month with $798 covering the essential health benefits. Given the actual cost of its QHP, the household can use only $798 of its $1,000 APTC and pay $2 a month out of pocket. Therefore, $202 of the APTC would go unused (unless, as discussed below, it spends some of the extra unused APTC on a separate pediatric dental plan).

i) Premiums Paid by Another Person

If an individual or entity pays premiums on behalf of a household, those payments are offset against the premium costs incurred by the household. For example, premiums paid by a Tribe on behalf of a tribal member or by a non-custodial parent on behalf of a child count toward the actual premiums paid. [149]

ii) Allocation of Actual Premium Costs when Multiple Tax Households Purchase a Plan Together

In some instances, a household may buy a plan together even if not all of the household members are part of the same tax household for APTC purposes. When this occurs, a formula is used to allocate the premium costs among the tax households to ensure that none is receiving a premium assistance credit in excess of actual costs. The premium costs are apportioned based on the relative cost of the benchmark plans used to determine the APTC of each tax household within the household. [150]

Example: Consider a couple whose 22-year old son is living with them even though he is employed and will need to file his own taxes. Assume that the benchmark plan for the couple costs $12,000 and $4,000 for the son. When assessing whether the couple would otherwise receive an APTC in excess of its actual premium costs, HealthSource RI must assume that it pays for three-quarters of the cost of any plan that the family purchases together ($12,000 / ($12,000 + $4,000) = 3/4ths). Even if the couple pays for the entire plan, its APTC is limited to 3/4ths of the cost of the purchased QHP. Similarly, the son is treated as paying for 1/4th of the cost of any QHP ($4,000 / ($12,000 + $4,000) = 1/4th) regardless of how much money he contributes toward the cost of the QHP. If the family bought a $10,000 plan, the couple would be treated as spending $7,500 on the plan (limiting its premium assistance credit to $7,500) and the son would be treated as spending $2,500 (limiting his premium assistance credit to $2,500).

4) Treatment of Non-Essential Health Benefits

As mentioned earlier in this Chapter, APTCs are available only to support the cost of purchasing essential

[148] 26CFR1.36B(3)
[149] 26CFR1.36B-3(c)(2)
[150] 26CFR1.36B-3(h)

health benefits.[151] APTCs may not be used to subsidize the cost of optional benefits, including elective abortions.[152] As a result, when determining the cost of the benchmark plan and actual premiums paid, only the portion of QHP costs attributable to essential health benefits is counted.

Example: A household selects a QHP that includes several optional non-essential health benefits, such as adult dental coverage. The cost of the household's QHP is $15,000, but $1,000 is attributable to the cost of the adult dental coverage and the other non-essential health benefits. When assessing whether the household's APTC exceeds actual premium costs, HealthSource RI would treat the household as having only $14,000 in actual premium costs. Similarly, when identifying the applicable benchmark plan, HealthSource RI would take into account only the cost of the essential health benefits offered by silver-level QHPs.

5) Treatment of Pediatric Dental Benefits

Pediatric dental benefits are considered part of EHBs and therefore their cost can be offset by APTCs. [153] However, some special rules apply to pediatric dental benefits and their role in the APTC calculation. Specifically, IRS regulations treat differently the cost of pediatric dental coverage when it is embedded in a QHP versus when it is provided through a separate dental-only plan. If embedded in a QHP, the cost of pediatric dental coverage **is** counted toward the cost of the applicable benchmark plan used to determine the size of a family's APTC. This has the effect of increasing the size of the family's APTC and subsidizing its purchase of dental coverage. On the other hand, if pediatric dental coverage is not embedded in the second-lowest-cost silver plan (SLCSP) available on HealthSource RI, then the cost of stand-alone dental **is not** added to the cost of the family's applicable benchmark plan.

These special rules apply when HealthSource RI is determining the cost of a family's applicable benchmark plan, but not when it is assessing whether a family's APTC falls below its actual premium costs. As a result, if a family elects to purchase a QHP but does not need to use the entire APTC to cover the purchase of the plan, it can apply some or all of the "excess" APTCs toward the cost of the dental plan.

Example: Consider a single mom with two kids who purchases a QHP that costs $400 a month and a stand-alone dental plan for both of her children that costs a total of $50 a month. When evaluating the cost of the applicable benchmark plan for her family (and, thus, the size of her tax credit), HealthSource RI cannot take into account the cost of her children's dental coverage. If, however, she purchases a QHP for $450 that includes pediatric dental coverage embedded in it, the applicable benchmark plan used to calculate her APTC will be based on the cost of the second lowest cost silver plan that includes pediatric dental benefits.

D. Eligibility for Cost Sharing Reductions (CSRs)

Households with a projected annual income of up to 250% of the FPL - with exceptions for American Indian and Alaska Native applicants (AI/AN) - are eligible for cost sharing reductions (CSRs) that reduce out-of-pocket spending.154

[151] 26CFR1.36B-3(j)
[152] ACA Section 1303; 45 CFR 156.280.
[153] 26CFR1.36B-3(k)

[154] 45 CFR 155.305(g)(C)

Households with lower incomes within this range will receive more financial assistance with out-of-pocket spending on health benefits while those at the higher end of the range receive less assistance. To be eligible for CSRs, applicants must enroll in a silver-level QHP155 (with exceptions for AI/AN applicants). CSRs allow households and individuals to enroll in "variations" of silver-level QHPs that have a higher "actuarial value." The actuarial value of a plan is the share of covered health care expenses that a QHP can be expected to cover for a standard population given its deductible, maximum limit on out-of- pocket costs, and other cost-sharing polices. As shown in Table 5 below, there are three major tiers of cost-sharing reductions.

Table 5. Tiers of Cost-Sharing Reductions Available to Households Enrolling in a Silver-Level Plan

Tier	Population	Silver-Level Plan Actuarial Value
Tier 1	100% FPL – 150% FPL (plus special populations below 100% FPL)	94%
Tier 2	150% FPL – 200% FPL	87%
Tier 3	200% FPL – 250% FPL	73%

In addition, as discussed in more detail below, AI/AN applicants are eligible for special cost sharing reductions.[156] AI/AN applicants under 300% of the FPL receive 100% cost sharing reductions for any level QHP in which they enroll.[157]

QHP issuers are required to submit to HealthSource RI annually prior to each benefit year the following plan variations (as well as variations for AI/AN enrollees):

- Silver-level plan QHP <150% FPL
- Silver-level plan QHP 150%-200% FPL
- Silver-level plan QHP 200%-250% FPL

The variations reflect differences in the cost-sharing charges associated with a plan; issuers must cover the same benefits and offer the same provider network to individuals enrolled in the CSR variations as they provide to individuals under the standard silver-level QHP. HealthSource RI assigns applicants to one of the silver-level QHP variations based on income, subject to the special rule on family policies.[158]

1) Eligibility for Cost Sharing Reductions (CSR)

People who apply for financial assistance are automatically assessed for CSR eligibility and do not have to complete a separate application. Individuals are eligible for a CSR if they:[159]

- Meet the eligibility criteria for an APTC, including QHP requirements[160] (See Chapter 2)

[155] 45 CFR 155.305(g)(C)(ii)
[156] 45 CFR 155.350
[157] 45 CFR 155.350(a)(2)

[158] 45 CFR 156.410(b)(1)
[159] 45 CFR 305(g)
[160] 45 CFR 155.305(g)(A)

- Anticipate having annual household income at or below 250% FPL[161] (with exceptions for AI/AN applicants)
- Enroll in a silver-level QHP (with exceptions for AI/AN applicants).[162]

CSRs are not available for catastrophic plans or stand-alone pediatric dental plans.[163,164]

Example: Consider a household of two parents and two children with projected annual household income of 210% FPL. The children are eligible for Medicaid and the parents are eligible for APTCs. The parents receive an APTC and choose to enroll in a silver-level QHP. The parents must be assigned to the silver-level QHP variation for families with incomes 200%-250% FPL if they want to take advantage of the CSR benefit.

Example: Consider the same example, except that the parents choose to enroll in a gold-level QHP. As a result, they're not eligible for a CSR because they're not in a silver-level QHP.

2) Changes in Eligibility for Cost-Sharing Reductions

If HealthSource RI notifies a Carrier of a change in an Enrollee's eligibility for CSRs, the Carrier must change the Enrollee's assignment such that the Enrollee is assigned to the applicable standard plan or plan variation as required under 45 C.F.R. § 156.410(b) as of the effective date of eligibility required by HealthSource RI.[165]

In the case of assignment to a new silver plan (or standard plan without cost-sharing reductions) of the same QHP during the course of a coverage year, the Carrier must ensure that any cost sharing paid by the covered individual or household under previous plan variations (or standard plan without cost-sharing reductions) applicable to that coverage year is taken into account in the new plan (or standard plan without cost-sharing reductions) for the purposes of calculating cost sharing based on aggregate spending by the covered individual/household, such as for deductibles and annual out-of-pocket limitations on cost sharing.[166] Meaning, if eligibility for cost sharing reduction plans shifts from one tier to another mid-year, any out of pocket contributions already paid towards health costs such as the deductible will carry over between plans.

In the case of assignment to a new silver plan variation (or standard plan without cost-sharing), the Carrier shall within 10 (ten) business days send the covered individual/household written notice explaining the new cost-sharing now applicable for the Enrollee.

The Carrier shall not be required to send a new member ID card to the covered individual/household to reflect new cost-sharing, except upon an annual renewal during which any elements of cost sharing displayed on the member ID card will be different than it was in the prior year.

3) Special Rules

[161] 45 CFR 305(g)(C)
[162] 45 CFR 155.305(g)(C)(ii)
[163] 45 CFR 156.440
[164] 45 CFR 156.440
[165] 45 C.F.R. § 156.425(a)
[166] 45 C.F.R. 156.425(b)

There are special CSR rules for non-citizens who are lawfully present and ineligible for Medicaid due to immigration status and for families that include individuals qualifying for different CSR levels.

a) Non-Citizens Lawfully Present Who Are Ineligible for Medicaid Due to Immigration Status

Lawfully present non-citizens with anticipated annual household income of less than 100% FPL who are ineligible for Medicaid due to immigration status are eligible for CSRs.[167] For purposes of assigning them to a silver-level QHP variation, they are treated as if their incomes are within the 100-150% FPL income range and are assigned to the silver-level QHP variation for families in this range.

b) Special Rule for Families That Include Individuals Qualifying for Different CSR Levels

In some instances, families purchasing a plan together will include individual members who qualify for different levels of CSR. For example, a family might include both a Native member and a non-Native member. In these instances, a "least common denominator" rule applies under which the family can only enroll in the CSR variation available to the member who qualifies for the least generous CSR. When at least one family member is entirely ineligible for a CSR, the family must forego a CSR if it wants to purchase coverage together.[168]

Example: Consider a couple with projected annual household income of 260% FPL in which the woman is a tribal member while her husband is not. If the couple purchases a QHP together, they would not be eligible for any CSRs because he does not qualify for a CSR.

4) American Indian/Alaska Native (AI/AN) Population

There are special CSR rules for American Indians and Alaska Natives.[169] An American Indian is a person who is a member of an Indian tribe, band, nation, or other organized group or community, including Alaska Natives, which is recognized as eligible for special programs and services provided to Indians.[170] Information about verifying Indian status can be found in Chapter 7.

a) No Cost Sharing Obligation for AI/AN < 300% FPL

AI/AN applicants who enroll in a QHP, are eligible for an APTC, and have projected annual household income below 300% FPL may enroll in a QHP with no cost sharing obligations (known as a "zero cost sharing plan").[171] Unlike other CSR-eligible individuals, AI/AN are not required to enroll in a silver-level QHP to qualify for a CSR. They are permitted to enroll in any level QHP and have no cost sharing obligations.[172]

b) Limited Cost Sharing Obligation for All Other AI/AN

[167] 26 CFR 1.36B-(c)(1)(B)
[168] 45 CFR 155.305(g)(3))
[169] 45 CFR 155.155.350; 45 CFR 156.410(b)(2)&(3))
[170] 25 USC § 450(b).
[171] 45 CFR 155.350(a)(ii)
[172] 45 CFR 155.350(a)(ii)(2)

All other AI/AN QHP applicants (i.e., those above 300 percent of the FPL and those who elect not to apply for an insurance affordability program) are automatically enrolled in the "limited cost sharing plan" variation (unless they are part of a family with non-Indians as explained above under the special family policy rule) of any QHP level that they select.[173] Under a limited cost-sharing plan, households have no cost-sharing obligation for items or services furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.[174]

Example: An AI/AN household with projected annual household income of 200% FPL is found eligible for an APTC and eligible for CSRs. The household enrolls in a gold-level QHP. The household is assigned to the zero-cost sharing bronze QHP variation and has no cost sharing obligations.

Example: An American Indian household has projected income of 500% FPL and enrolls in a gold-level QHP. The household is assigned a limited cost sharing gold QHP variation under which it cannot be charged cost-sharing for using services provided by the Indian Health Service and selected other AI/AN providers.

E. Appendix

1) Appendix A. Treatment of Wellness Incentives and Employer Contributions to HRAs and Health Savings Accounts (HSAs) in Calculating MV

With the exception of wellness programs designed to prevent or reduce tobacco use, nondiscriminatory wellness program incentives offered by an eligible employer---sponsored plan that reduce cost---sharing are **not** considered to count toward determining the plan's MV percentage (i.e., MV will be determined assuming that all employees fail to satisfy the requirements of the wellness program). In circumstances involving tobacco cessation programs, incentives are considered to count toward determining the plan's MV percentage (i.e., MV will be determined using the assumption that each employee satisfies the requirements of the wellness program).[175]

Example: Consider an employer that offers an eligible employer-sponsored plan with a nondiscriminatory wellness program that reduces premiums by $300 for employees who do not use tobacco products or who complete a smoking cessation course. Premiums are reduced by $200 if an employee completes cholesterol screening within the first six months of the plan year. One employee (Employee A) does not use tobacco and the cost of his premiums is $3,700. Another employee (Employee B) uses tobacco and the cost of her premiums is $4,000.

Only the incentives related to tobacco use are considered in determining the plan's actuarial value percentage. Accordingly, Employee B is treated as having earned the $300 incentive for attending a smoking cessation course. Thus, the deductible for determining the MV percentage for both Employees A and B is $3,700. The $200 incentive for completing the cholesterol screening is disregarded.[176]

All employer contributions for the current plan year to an HSA will be taken into account in that plan year towards

[173] 45 CFR 156.410(b)(3)
[174] 45 CFR 155.350(b); 45 CFR 156.410(b)(2)
[175] 26 CFR 1.36B-6(c)(2)(i)
[176] 26 CFR 1.36B-6(c)(2)(ii)

the plan's MV percentage (i.e., employer contributions are taken into account in determining the plan's share of costs for MV and treated like amounts available for first dollar coverage).[177] Similarly, amounts made newly available under an HRA that is integrated with an eligible employer-sponsored are taken into account for that plan year towards the plan's MV percentage provided that employees can only use the amounts to reduce cost-sharing (not pay premiums).[178]

Table A-1. Applicability of Incentive/Amount to Premiums in Order to Determine MV

Wellness Program – Non-Tobacco Cessation	No. MV determined assuming employee fails to earn incentive/complete program.
Wellness Program – Tobacco Cessation	Yes. MV is determined assuming employee earns incentive/completes program.
Employer HSA Contribution	Yes.
HRA Contribution	Yes, but only if HRA amounts cab be used only for reduced cost sharing.

2) Appendix B: Expected Premium Contribution by Family Size

The expected premium contribution for households is subject to change each year. Applicable percentages for 2015 coverage are available at: www.irs.gov/pub/irs-drop/rp-14-37.pdf. Please visit the IRS website for the most current listings of applicable percentages.

[177] 26 CFR 1.36B-6(c)(3)
[178] Proposed 26 CFR 1.36B-6(c)(4)

Chapter 5: Advance Premium Tax Credit Reconciliation

A. Advance Premium Tax Credit (APTC) Reconciliation Overview

As discussed in detail in Chapter 4, households with low and moderate incomes may be eligible to receive a premium tax credit from the federal government to help lower the cost of buying a Qualified Health Plan (QHP) through HealthSource RI.[179] Tax credits are subsidies provided by the federal government directly to health insurance companies to help individuals and families pay for QHP premiums. Though HealthSource RI determines eligibility for APTCs, HealthSource RI does not administer federal tax credits directly, nor does HealthSource RI control the amount of APTCs that an individual or family may take. Recipients of tax credits are responsible for the amount of APTCs they choose to take in advance.

Eligible individuals can receive the premium tax credit monthly (called advance premium tax credit or APTC), at the end of the tax year when filing their federal income taxes, or monthly during tax season. Customers may take some of the credit in advance and receive the remainder when they file their taxes (a "combination approach"). If an individual receives APTCs, the Internal Revenue Service (IRS) conducts a reconciliation process to ensure that the individual received the appropriate amount of tax credit.[180] The IRS compares the premium tax credit the individual received in advance with the amount of the premium tax credit the individual was actually eligible to receive based on his or her income.

This reconciliation is required by law[181] and is designed to ensure that any tax credits received in advance, which are based on estimated income, align with the customer's final tax credit eligibility, which is determined by the IRS at the end of the tax year using actual income generated that calendar year. If a customer's actual income is higher than his or her estimated income, the customer may have to pay back some of those tax credits to the federal government; if a customer's actual income is lower than his or her estimated income, the customer may receive additional federal tax credits at tax time.

Individuals and families are obligated to report any changes that could cause the amount of their APTC to change. For example, customers must alert HealthSource RI if they change jobs, have a baby, get married, divorced, or go through any number of other changes. However, some individuals may not always report changes in a timely manner and, even if they do, it may not always be possible to avoid reconciliation of tax credits at the end of the tax year. If HealthSource RI is unaware of a change in a household's circumstances, it cannot take action to recalculate their APTCs, increasing the risk that the household will be obligated to owe money to the IRS at the end of the tax year.

Cost Sharing Reductions (CSRs) are not subject to reconciliation for individuals and are not discussed in this chapter.

B. Option to Receive Premium Tax Credit in Advance

[179] 26 CFR § 1.36B-2(a)
[180] 26 CFR § 1.36B-4(a)(1)(i)-(ii)
[181] 26 CFR **§** 1.36B-4(a)(i)

Individuals who qualify for a premium tax credit may choose to receive the premium tax credit in one of three ways:

- ***APTC (Advanced Premium Tax Credits):*** *Customers receive these tax credits In advance when they purchases a QHP, and each month as a premium payment is due*. For individuals who choose to receive the premium tax credit in advance, the tax credit is sent directly from the IRS to the health insurance company. This approach allows individuals to receive assistance each month instead of at the end of the year when they file their taxes. When individuals receive an APTC, their tax credit amount is based on their estimated income for the taxable year. Individuals and families can choose to reduce the amount of tax credits they receive in advance to limit the risk that they will need to pay back some of those credits at the end of the year.[182]
- ***Premium Tax Credit:*** *Customers receive their tax credits at the end of the taxable year when they file their federal income taxes*. In this instance, the amount of the premium tax credit is calculated based on the tax filer's actual income, making it unnecessary to conduct a reconciliation process.
- ***Combination Approach:*** *In this case, Individuals choose to receive <u>some</u> of their premium tax credit upfront in the form of APTCs and the remainder, if any, at tax filing time.* During the online enrollment process, enrollees have the opportunity to utilize a sliding scale to select, within their maximum eligibility, the amount of tax credits they will receive on a monthly basis. Enrollees who select a tax credit amount below their maximum eligibility will receive any remaining tax credits at the end of the tax year.

Example: Bob submits an application for health coverage and estimates that his annual income will be 200% FPL. HealthSource RI finds that Bob is eligible for $3,752.00.[183] in tax credits.

Bob has three options at the point of application:

(1) Receive $3,752 in advance ($313 each month); or
(2) Receive some amount in advance, for example $1,876 in advance ($156 each month), and the other $1,876, at the end of the tax year; or
(3) Receive all $3,752 at the end of the tax year.

If Bob's actual annual income at tax filing time is different than he anticipated, the size of his premium tax credit will be adjusted accordingly. If he chooses to receive all or some of his anticipated credit in advance, his tax return will be subject to reconciliation meaning he will pay back some of the tax credit paid out on his behalf.

1) Reconciling Advance Premium Tax Credits at End of Year

Taxpayers must reconcile all premium tax credits they receive in advance, including credits they receive on behalf of members of their family.**[184]** The final premium tax credit amount is calculated based on actual income reported when individuals file their federal income taxes.[185] The IRS compares the amount of APTCs the individuals received

[182] 45 CFR 155.310(d)(2)
[183] All examples in this Chapter are used for illustrative purposes only. Numbers may not add due to rounding. All of the examples use a benchmark premium of $5,200.
[184] See generally 26 CFR 1.36B-4
[185] 26 CFR 1.36B-4(2)

to the premium tax credit they are eligible for based on their actual income as reported on their federal income taxes.
If APTCs received during the year are less than the amount of the premium tax credit for which an individual qualifies when taxes are filed, the individual will receive the difference in the form of a refundable tax credit.

If the advance premium tax credit for the year is more than the amount of the premium tax credit for which an individual qualifies when taxes are filed, the individual must repay the excess advance payments with their tax return filing.

Example: Sally applies for health coverage and estimates that her annual income will be $35,000. Sally is eligible for a premium tax credit in the amount of $2,000. Sally chooses to receive all of the $2,000 premium tax credit in advance ($166.66 each month) and it reduces the amount she must pay in monthly premiums.

At the end of the year when Sally files federal income taxes, her actual annual income is $28,000. Based on her actual annual income, Sally is eligible for a $2,500 tax credit. Because the premium tax credit Sally received in advance was $2,000 and she actually qualifies for a $2,500 tax credit, Sally will receive a tax refund of $500 when she files her federal income taxes.

Example: Richard applies for health coverage and estimates that his annual income will be $28,725 (250% FPL). Richard is eligible for a premium tax credit in the amount of $2,888. Richard receives all of the $2,888 premium tax credit in advance ($240.64 each month) and it reduces his monthly premium throughout the year. At the end of the year when Richard files federal income taxes, his actual annual income is $34,585 (301% FPL). Based on his actual annual income, Richard is eligible for a $1,914 premium tax credit. Because the premium tax credit Richard received in advance is $2,888 and the premium tax credit he is eligible for at the end of the year is $1,914, Richard must repay the $974 of excess premium tax credits he received in advance.

a) Reconciliation Process & Applicable IRS Forms

HealthSource RI will mail IRS Form 1095-A, *Health Insurance Marketplace Statement* to all customers in early February of the following year.[186] Once the form is mailed, HealthSource RI will also post a PDF copy in each customer's online account, where it can be downloaded and printed. Customers should keep their Form 1095-A with all their tax records so they can use it as a reference tool when they are ready to file taxes.

Form 1095-A provides information needed to complete IRS Form 8962. For any tax year, individuals or families receiving advance credit payments in any amount (or who plan to claim the premium tax credit), must file a Form 8962, *Premium Tax Credit (PTC)*, and attach it to their federal income tax return for that year.[187]
Customers receiving APTCs will use their federal tax return to reconcile the difference between the advance credit payments made on their behalf and the actual amount of the credit that they are entitled to claim. This filing requirement applies whether or not an individual would otherwise be required to file a return.

If customers are enrolled in health insurance through HealthSource RI and chose to receive a tax credit in advance to help pay their monthly premiums, the IRS will use Form 8962, along with other information in their tax filing

[186] See Chapter 5 Appendix for a sample IRS Form 1095-A.
[187] See Chapter 5 Appendix for a sample IRS Form 8962.

(like information on income and family size), to make sure they received the right amount of tax credit. If they receive more in tax credits than is owed to them, the difference will be added to their final tax due or subtracted from their refund. If customers enrolled in health insurance through HealthSource RI without a tax credit (meaning they paid the full monthly premium), they may use Form 8962 to determine if they are eligible for a tax credit when they submit their tax filing.

a) What is Form 1095-A?

Form 1095-A is a form customers use to fill out their taxes. They should keep it with their tax records so they can use it when they are ready to file. Form 1095-A is produced each year by HealthSource RI for any individual or family who enrolled in health insurance for any period of time. It has information about the health insurance individuals and families received through HealthSource RI.

Form 1095-A has three parts. Part I provides basic information about customers and their health insurance start and end dates. Part II provides information about each member of the "coverage household" – those members of the family also covered under the same policy. Part III provides information for every month of the year about:

- (1) The monthly premium amount of the health plan the customer selected
- (2) The premium amount of the Second Lowest Cost Silver Plan (SLCSP) available on the exchange
- (3) The advance payment of the premium tax credit paid on the customer's behalf to the health insurance company that offers his or her plan.

If a customer or member of his or her tax household is enrolled in more than one health plan, **the customer will receive a Form 1095-A for each plan.** Customers should use all of the 1095-A forms they receive where they are listed as a "Covered Individual" (in Part II) to fill out Form 8962.

Form 1095-A will be sent to the person identified as the tax filer. HealthSource RI will not send the form to anyone except the tax flier.

If a member of a customer's household was enrolled in Medicaid coverage, even only for one month, the customer will also receive a **1095-B.** 1095-Bs are governed by Medicaid. For additional information regarding your 1095-B please refer to http://www.eohhs.ri.gov/ or for tax related questions https://www.irs.gov/uac/about-form-1095-b

b) Tax Repayment is Capped for Individuals With Actual Income Less Than 400% of the FPL

Individuals who receive an advance premium tax credit that is more than the amount of the premium tax credit for which they qualify at the end of the year must repay the excess when they file taxes.[188] However, for individuals with household income below 400% of the FPL at the end of the year, the amount that must be repaid is capped based on income according to the IRS. Additional information is available at: https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit

c) No Cap on Repayment Obligations for Individuals with Actual Income Above 400% FPL

[188] 26 CFR 1.36B-4(a)(3)

Individuals with taxable income above 400% of the FPL are not eligible for a premium tax credit. If individuals receive APTCs based on an estimate that their income will be below 400% of the FPL, they must return all advance premium tax credits they received during the year if their actual year-end taxable income is above 400% of FPL. There is no cap on the repayment obligation for individuals and families in this income bracket.[189] Please see IRS Publication 974 for additional information.

Example: When Alice applies for coverage, she anticipates having annual household income of 250% FPL. Alice receives an advance premium tax credit in the amount of $2,888 ($241 per month). At the end of the year when Alice files her federal income taxes, her household income is 410% FPL. Alice must pay back the $2,888 when she files her federal income taxes at the end of the year.

d) Rule for Individuals with Annual Household Income Below 100% FPL at End of Year

In general, individuals with income below 100% of the FPL are not eligible for a premium tax credit (see Chapter 4).[190],[191] However, if an individual anticipates that his or her annual income will qualify him or her for a premium tax credit, but at the end of the year the individual's actual taxable income falls below 100% of the FPL, the individual is not required to repay the APTC. The individual is eligible for the premium tax credit and, for reconciliation purposes, the amount of tax credit is calculated based on actual income as reflected on the tax return.[192] Please see IRS Publication 974 for additional information.

Example: When Robert applies for coverage, he anticipates having annual household income of 150% FPL. Robert is eligible for a premium tax credit in the amount of $4,511 ($376 per month) and he chooses to receive it all in advance. At the end of the year when Robert files his federal income taxes, his household income is 90% FPL, so Robert's household income is below 100% FPL. Robert is not required to pay back the premium tax credit he received in advance.

e) Treatment of APTCs Received During a Grace Period

Under federal regulations, individuals receiving APTCs who have made an initial premium payment but subsequently fail to pay a monthly premium are given a three-month grace period.[193] Where individuals have not repaid their premiums by the end of the three months, their coverage may be terminated retroactive to the end of the first of those three months. The individuals must pay back the tax credits paid on their behalf for the first month of the grace period if they do not pay for their share of the premium that month. Note that the grace period issue applies only to individuals who are enrolled in coverage but fail to make premium payments.

C. Implications of Mid-Year Changes for APTC Reconciliation

Customers are obligated to report to HealthSource RI any changes that may impact APTC eligibility that occur during the year, such as changes in income, family size, access to minimum essential coverage, or tax filing status.

[189] 26 CFR 1.36B-4(a)(3)(ii)
[190] 26 CFR 1.36B-2(b)(6)
[191] Lawfully present immigrants who are ineligible for Medicaid based on immigration status and whose household income falls below 100% of the FPL still may be eligible for a premium tax credit. Such individuals must be lawfully present and must meet all of the other premium tax credit eligibility criteria that apply to individuals with income at or above 100% of the FPL. See Chapter 4 on APTC eligibility.
[192] 26 CFR 1.36B-2(b)(7)
[193] 26 CFR 1.36B-4(a)(iii); 45 CFR 156.270 (d)

Changes must be reported within 30 days of when they occur.[194] When HealthSource RI is notified of a change or identifies a change through periodic data matching with external data sources, it must recalculate the household's income and adjust the APTCs in accordance with IRS requirements. By doing so, HealthSource RI reduces the risk that customers will face a repayment obligation at the end of the tax year.[195] When taxpayers marry or divorce, they face some special reconciliation rules, described in Section C-2 below.

1) General Rule for Adjusting APTCs to Reflect Mid-Year Changes

When an individual applies for health coverage, he or she provides information on the amount of income his or her household anticipates it will earn for the entire year. During the course of the year, a household's income or size may increase (e.g., due to a new job, drop in household size when a child leaves home), or decrease (e.g., due to loss of a job, or increase in household size after a birth). When such changes occur, HealthSource RI must recalculate income and adjust a household's APTCs.[196] Specifically, it must recalculate the APTC to reflect: 1) the household's new projected annual income for the taxable year, and 2) any "overpayments" or "underpayments" in the amount of APTCs received to date.

Below is a non-exhaustive list of changes reported by a household that necessitate HealthSource RI to recalculate a household's APTCs:

- An increase or decrease in income;
- Someone in the household gives birth or adopts a child;
- A dependent who was not expected to be required to file taxes now appears likely to need to;
- A marriage;
- A divorce; or
- A change in access to minimum essential coverage (MEC).

2) HealthSource Data Quality Assurance

HealthSource RI conducts periodic data quality checks to ensure the correct coverage plan, premium, and tax credits are being applied to all QHP customers. This is part of our commitment to ensure customers are subject to as little reconciliation as possible. If an error is found impacting one or more of the billing, enrollment, and carrier systems, HSRI will make the adjustment to customer accounts to minimize any potential for disruption to coverage. This may result in an update to a customer's eligibility, with the potential for an increase or decreased bill. When an update happens to a customer's account, they will receive updated notice(s) informing them of any change in eligibility or plan cost which may have occurred. Customers have the right to appeal these decisions if they disagree, as described in Chapter 9.

3) Special Rule for Newly-Married Couples

A marriage often results in an increase in income due to the family gaining multiple sources of income. However,

[194] 45 CFR 155.330(b)
[195] 45 CFR 155.330(g)
[196] 45 CFR 155.330(e)(1)

even if the individuals accurately projected their own incomes while still single and promptly reported their marriage, they may nevertheless face an APTC repayment obligation at the end of the tax year. To mitigate this risk, the IRS allows newly married couples to rely on an alternative computation of their premium tax credit for reconciliation purposes, if the alternative computation works to their benefit.[197] Please see IRS Publication 974 for additional information.

4) Special Rule for Newly-Divorced Couples

When couples divorce over the course of a year and become single, they must decide how to allocate key elements of the APTC calculation and reconciliation process.[198] For example, if they received too much APTC, they must allocate the repayment obligation between the two of them. Similarly, for purposes of reconciliation, they must allocate the premium for the applicable benchmark plan and the premium for the plan in which they were enrolled (as discussed in Chapter 4, these two factors are a key component of the formula that determines the size of premium tax credits). Please see IRS publication 974 for additional information.

[197] 26 CFR 1.36B-4(b)(2)
[198] 26 CFR 1.36B-4(b)(3)

D. Appendix

Sample IRS Form 1095-A

Form **1095-A**

Department of the Treasury
Internal Revenue Service

Health Insurance Marketplace Statement

► **Information about Form 1095-A and its separate instructions is at *www.irs.gov/form1095a.***

☐ CORRECTED

OMB No. 1545-2232

2014

Part I **Recipient Information**

1 Marketplace identifier	**2** Marketplace-assigned policy number	**3** Policy issuer's name	
4 Recipient's name		**5** Recipient's SSN	**6** Recipient's date of birth
7 Recipient's spouse's name		**8** Recipient's spouse's SSN	**9** Recipient's spouse's date of birth
10 Policy start date	**11** Policy termination date	**12** Street address (including apartment no.)	
13 City or town	**14** State or province	**15** Country and ZIP or foreign postal code	

Part II **Coverage Household**

	A. Covered Individual Name	**B.** Covered Individual SSN	**C.** Covered Individual Date of Birth	**D.** Covered Individual Start Date	**E.** Covered Individual Termination Date
16					
17					
18					
19					
20					

Part III **Household Information**

Month	**A.** Monthly Premium Amount	**B.** Monthly Premium Amount of Second Lowest Cost Silver Plan (SLCSP)	**C.** Monthly Advance Payment of Premium Tax Credit
21 January			
22 February			
23 March			
24 April			
25 May			
26 June			
27 July			
28 August			
29 September			
30 October			
31 November			
32 December			
33 **Annual Totals**			

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60703Q Form **1095-A** (2014)

2. Sample IRS Form 8962

Form **8962**

Department of the Treasury
Internal Revenue Service

Premium Tax Credit (PTC)

▶ **Attach to Form 1040, 1040A, or 1040NR.**
▶ **Information about Form 8962 and its separate instructions is at *www.irs.gov/form8962*.**

OMB No. 1545-0074

2014

Attachment Sequence No. **73**

Name shown on your return | Your social security number | Relief (see instructions) ☐

Part 1: Annual and Monthly Contribution Amount

1	Family Size: Enter the number of exemptions from Form 1040 or Form 1040A, line 6d, or Form 1040NR, line 7d	1	
2a	Modified AGI: Enter your modified AGI (see instructions) — 2a	b Enter total of your dependents' modified AGI (see instructions)	2b	
3	Household Income: Add the amounts on lines 2a and 2b	3	
4	Federal Poverty Line: Enter the federal poverty amount as determined by the family size on line 1 and the federal poverty table for your state of residence during the tax year (see instructions). Check the appropriate box for the federal poverty table used. **a** ☐ Alaska **b** ☐ Hawaii **c** ☐ Other 48 states and DC	4	
5	Household Income as a Percentage of Federal Poverty Line: Divide line 3 by line 4. Enter the result rounded to a whole percentage. (For example, for 1.542 enter the result as 154, for 1.549 enter as 155.) (See instructions for special rules.)	5	%
6	Is the result entered on line 5 less than or equal to 400%? (See instructions if the result is less than 100%.) ☐ **Yes. Continue to line 7.** ☐ **No.** You are not eligible to receive PTC. If you received advance payment of PTC, see the instructions for how to report your Excess Advance PTC Repayment amount.		
7	Applicable Figure: Using your line 5 percentage, locate your "applicable figure" on the table in the instructions	7	
8a	Annual Contribution for Health Care: Multiply line 3 by line 7 — 8a	b Monthly Contribution for Health Care: Divide line 8a by 12. Round to whole dollar amount	8b	

Part 2: Premium Tax Credit Claim and Reconciliation of Advance Payment of Premium Tax Credit

9 Did you share a policy with another taxpayer or get married during the year and want to use the alternative calculation? (see instructions)
☐ **Yes.** Skip to Part 4, Shared Policy Allocation, or Part 5, Alternative Calculation for Year of Marriage. ☐ **No. Continue to line 10.**

10 Do all Forms 1095-A for your tax household include coverage for January through December with no changes in monthly amounts shown on lines 21–32, columns A and B?
☐ **Yes. Continue to line 11.** Compute your annual PTC. Skip lines 12–23 and continue to line 24. ☐ **No. Continue to lines 12–23.** Compute your monthly PTC and continue to line 24.

Annual Calculation	**A.** Premium Amount (Form(s) 1095-A, line 33A)	**B.** Annual Premium Amount of SLCSP (Form(s) 1095-A, line 33B)	**C.** Annual Contribution Amount (Line 8a)	**D.** Annual Maximum Premium Assistance (Subtract C from B)	**E.** Annual Premium Tax Credit Allowed (Smaller of A or D)	**F.** Annual Advance Payment of PTC (Form(s) 1095-A, line 33C)
11 Annual Totals						
Monthly Calculation	**A.** Monthly Premium Amount (Form(s) 1095-A, lines 21–32, column A)	**B.** Monthly Premium Amount of SLCSP (Form(s) 1095-A, lines 21–32, column B)	**C.** Monthly Contribution Amount (Amount from line 8b or alternative marriage monthly contribution)	**D.** Monthly Maximum Premium Assistance (Subtract C from B)	**E.** Monthly Premium Tax Credit Allowed (Smaller of A or D)	**F.** Monthly Advance Payment of PTC (Form(s) 1095-A, lines 21–32, column C)
12 January						
13 February						
14 March						
15 April						
16 May						
17 June						
18 July						
19 August						
20 September						
21 October						
22 November						
23 December						

24	Total Premium Tax Credit: Enter the amount from line 11E or add lines 12E through 23E and enter the total here	24	
25	Advance Payment of PTC: Enter the amount from line 11F or add lines 12F through 23F and enter the total here	25	
26	Net Premium Tax Credit: If line 24 is greater than line 25, subtract line 25 from line 24. Enter the difference here and on Form 1040, line 69; Form 1040A, line 45; or Form 1040NR, line 65. If you elected the alternative calculation for marriage, enter zero. If line 24 equals line 25, enter zero. Stop here. If line 25 is greater than line 24, leave this line blank and continue to line 27	26	

Part 3: Repayment of Excess Advance Payment of the Premium Tax Credit

27	Excess Advance Payment of PTC: If line 25 is greater than line 24, subtract line 24 from line 25. Enter the difference here	27	
28	Repayment Limitation: Using the percentage on line 5 and your filing status, locate the repayment limitation amount in the instructions. Enter the amount here	28	
29	Excess Advance Premium Tax Credit Repayment: Enter the smaller of line 27 or line 28 here and on Form 1040, line 46; Form 1040A, line 29; or Form 1040NR, line 44	29	

For Paperwork Reduction Act Notice, see your tax return instructions. Cat. No. 37784Z Form **8962** (2014)

Chapter 6: MAGI Medicaid Eligibility

A. Overview of MAGI Medicaid Eligibility

This Chapter provides a brief overview of the rules for determining Medicaid eligibility. Individuals should always consult the most up-to-date Medicaid Rules & Regulations[199] for the most accurate information regarding Medicaid eligibility Rules. **Medicaid eligibility rules are set by the Executive Office of Health & Human Services (EOHHS), not by HealthSource RI. HealthSource RI is not the definitive source for the rules regarding Medicaid eligibility or for the most recent updates to those rules.**

Medicaid provides health coverage to eligible children, adults, pregnant women, the elderly, and people with disabilities who meet residency, citizenship, immigration, and financial eligibility standards.[200] This Chapter focuses on Medicaid eligibility for children, adults, and pregnant women for whom eligibility is based on Modified Adjusted Gross Income (MAGI). To be eligible for MAGI Medicaid, a family must meet the program's technical,[201] cooperation[202], characteristic[203], and financial requirements[204]. Please refer to the most up-to-date version of the Medicaid Rules & Regulations for more information regarding Medicaid eligibility requirements.

HealthSource RI adheres to a "No Wrong Door" policy, ensuring that any eligible Rhode Island resident may contact HealthSource RI to obtain information and assistance regarding their potential eligibility for MAGI Medicaid or QHP with or without financial help.

B. Coverage Groups

MAGI Medicaid eligibility is determined by rules governing specific coverage groups. A coverage group is a classification of individuals potentially eligible to receive Medicaid benefits. There are numerous coverage groups. An individual must satisfy all of the requirements of at least one coverage group to be eligible for MAGI Medicaid. Please refer to the most up-to-date version of the Medicaid Rules & Regulations for more information regarding coverage groups and financial standards for MAGI Medicaid.

Generally, the following coverage groups exist:

- Parents and Caretaker Relatives
- Pregnant Women
- Infants and children
- Adult Group - Individuals may be covered under this group if they:
    - Are aged 19-64;
    - Are not pregnant;

[199] available at http://www.eohhs.ri.gov/
[200] For an overview of government-sponsored health insurance care available in Rhode Island, please see the Medicaid Rules & Regulations, Ch. 0300.
[201] See Medicaid Rules & Regulations, 0300.25.05
[202] See Medicaid Rules & Regulations, 0300.25.15
[203] See Medicaid Rules & Regulations, 0300.25.10
[204] See Medicaid Rules & Regulations, 0300.25.20

- Are not entitled to or enrolled in Medicare part A or B benefits;
- Are not otherwise eligible for and enrolled in another coverage group; and
- Have household income that is at or below 133 percent of the Federal Poverty Level (FPL).[205,206]

C. Determining MAGI Medicaid Eligibility

1) Household Composition & Size

EOHHS identifies whether an applicant meets the eligibility criteria for MAGI Medicaid, by first determining which members of the applicant's family who are considered part of his or her household.[207] After the household is constructed, EOHHS can determine its household income and compare it to the FPL for a household of the appropriate size. There are some notable differences in the rules used for Medicaid eligibility as compared to eligibility for financial assistance for QHP enrollees.

First, there are a number of specific circumstances in which Medicaid household composition rules are different from the APTC/CSR rules. Second, Medicaid household rules are specific to each **individual** within a family or household. For example, an adult in a family may have a different Medicaid household than the child with whom he or she is living. In contrast, each person who is part of a taxpayer household for APTC/CSR eligibility purposes is considered to have the same household and the same household income.[208] Please refer to the most up-to-date version of the Medicaid Rules & Regulations for more specific information regarding household composition rules for Medicaid.

2) Household Income

In order to be eligible for MAGI Medicaid, an applicant's current monthly household income must meet certain income limits. As with APTC and CSR eligibility, Medicaid also relies on the IRS-based measure of income known as "Modified Adjusted Gross Income" [209] with some modifications,[210]. That said, there is a substantial difference when evaluating income for Medicaid versus eligibility for APTC/CSR. While HealthSource RI determines APTC/CSR eligibility using estimated annual income, EOHHS uses **current** monthly income to determine eligibility for Medicaid.[211] Please refer to the most up-to-date version of the Medicaid Rules & Regulations for more information regarding financial standards for Medicaid eligibility, including:

- Whose income is counted;
- What counts as household income; and
- What counts as household MAGI for purposes of evaluating Medicaid eligibility.

[205] Under federal law, adults covered under 42 CFR 119 may include parents and caretaker relatives with incomes above the limit set for the Parent and Caretaker Relative Group under 42 CFR 435.110 and below 133% FPL. However, because Rhode Island's income limit for the Parent and Caretaker Relative group under 42 CFR 435.110 is 133% FPL, coverage under 42 CFR 119 will be limited, as a practical matter, to adults without dependent children.
[206] Medicaid Rules & Regulations Ch. 1305.13.01(B)(1)(a)(i), 42 CFR 119
[207] 42 CFR 435.603(f)
[208] 42 CFR 435.603(f)
[209] 42 CFR 435.603(e)
[210] 42 CFR 435.603(e)
[211] 42 CFR 435.603(h)

Chapter 7: Verification of Eligibility for Insurance Affordability Programs

A. Overview of the Verification Process for Determining Eligibility

1) Attestation of Eligibility

Individuals applying for Medicaid, RIte Care, or a Qualified Health Plan, with or without financial help, are required to complete a single streamlined application. This application contains basic information about everyone in the household who is applying for health insurance so that HealthSource RI, the Executive Office of Health and Human Services (EOHHS), and the Department of Human Services (DHS) may determine the household's eligibility for health insurance coverage. Applicants are required to provide the following information for everyone in the household applying for coverage:

- Name
- Household composition
- Social Security Number (required for head of household and/or anyone applying who has one)
- Residency
- Modified Adjusted Gross Income (MAGI)
- Citizenship and immigration status
- Date of birth
- Incarceration
- Whether applicants are eligible for other health insurance (including other government sponsored Minimum Essential Coverage (MEC), including Medicare)

2) Identity Proofing

a. Overview

Identity Proofing is the process of confirming an applicant's identity. HealthSource RI verifies an applicant's identity using a service provided by Experian. Experian helps HealthSource RI ask specific questions about the applicants about their personal and financial history, such as previous addresses or jobs. These questions are specific enough that only the applicant should know the answers. ID proofing is a required step before HSRI can use electronic data sources to verify an applicant's eligibility for coverage or financial help. It is meant to prevent an unauthorized person from creating an account and applying for health coverage without the applicant's knowledge.

The applicant may be asked to submit documents to verify their identity. Acceptable documents are listed in the Identity chart in Chapter 7, section F.

b. Who is required to complete ID Proofing?

ID Proofing is required for the primary account contact who is applying for coverage for him/herself and/or on behalf of his/her family. Other individuals named in an application, who are not the primary account contact, are

not ID proofed. If a customer submits a paper application, they must log into an online account and complete ID proofing before they can access an online application. Individuals can complete ID proofing online or use assistance from the Contact Center. Certified Application Counselors cannot complete ID Proofing on behalf of an applicant.

c. What happens if a customer cannot complete online ID Proofing?

The applicant can call the Contact Center for manual ID proofing or come to the walk-in center with identification.

3) Database Verification

HealthSource RI will attempt to verify an applicant's personal information (such as income, Social Security Number, citizenship and immigration status) against a variety of state and federal data sources when available.[212] For more information, please refer to HealthSource RI's application policies on www.HealthSourceRI.com. In most cases, an applicant will need to provide personal information for HealthSource RI to determine the applicant's eligibility for health coverage and financial help. If this personal information cannot be verified, HealthSource RI will either prevent the applicant from enrolling in a QHP or offer "conditional eligibility" – allowing the applicant to continue with their application, enroll in coverage, but on the condition that the applicant submit more documents in the near future.[213]

HSRI performs a monthly check for accounts that have failed to provide the necessary documentation by the due date. If those documents were not provided in timely fashion, **HSRI will cancel the customer's financial assistance or coverage**, depending on which documents are missing.

Verification policies and procedures differ between applicants who are requesting financial support and those who are not. If the data sources match the applicant's attestation, or if the applicant's income provided is found "reasonably compatible"[214] as determined by the ACA with available data sources, the person's eligibility will be based on the information attested to by the applicant. If the data sources **do not** match the attestation within "reasonable compatibility", then HealthSource RI will ask the customer to provide documentation to help reconcile the discrepancy between the attestation and the data sources. We recognize many customers have income that fluctuates throughout the year. Because of that fluctuation, we give customers the chance to explain the income mismatch, or provide paystubs.

When a customer submits an application, HSRI verifies the information the applicant provided against a variety of state and federal data sources. If information found in the data source does not match the information provided by a customer, a customer's eligibility notice will say the customer is made "conditionally eligible" and include a request for documentation. The due date for the documentation is listed on the notice. HSRI takes action on accounts that fail to respond to the request in a timely fashion. Customers will be sent a warning about account action at least 30 days in advance of any action. Depending on the information HSRI needs to verify, customers may lose access to financial assistance or lose their coverage if they do not respond with the requested information within a timely fashion.

[212] 45 CFR 155.315
[213] 45 CFR 155.315(f)(4)(1)
[214] 45 CFR § 155.320(c)(1)(v)

For example, failure to provide timely information regarding one's immigration status may result in the loss of coverage, while failure to provide information regarding a customer's annual income may result in the removal of tax credits or change from a CSR plan to a non-CSR plan.

a. Reasonable Explanation

If HealthSource RI determines that an applicant's explanation for the discrepancy between his or her reported income and data from external data sources is reasonable, the applicant's final determination of eligibility will be based on the attestation provided. If the applicant's explanation is not determined to be reasonable to resolve the discrepancy, the applicant will be required to provide documentation to reconcile the discrepancy.

b. Verification Process and Conditional Eligibility

When applicants report an income level that would qualify their household for financial help, but that income cannot be verified by external data sources, applicants receive conditional eligibility, meaning they have 90 days to submit satisfactory documentation to verify their income.[215] During this 90-day period, customers receive conditional coverage and financial assistance.[216] This 90-day period is discussed further in section E of this Chapter.

If applicants do not take the requested steps to verify their personal information, their conditional eligibility will end after this 90-day period.[217] Additionally, applicants may have to pay back any tax credits paid on their behalf during this period.[218]

c. Eligibility Determination

If the applicant provides timely documentation, the applicant's eligibility will be based on the documentation provided.[219] If he applicant does not provide satisfactory income documentation within the required 90 days, and the applicant is not granted a good faith extension,[220] then the applicant's final eligibility will be based on available data sources.

B. Data Matching

1) Overview of Data Matching

HealthSource RI will attempt to verify an applicant's eligibility information through a variety of state and federal data sources. [221] For example, income will be verified against IRS, state wage collection agency, and unemployment income data. Social Security Numbers, age, and citizenship will be verified against Social Security Administration data. Immigration status will be verified against data from the Department of Homeland Security. HealthSource RI will accept self-attestation

[215] 45 CFR 155.315(f)(2)(ii)
[216] 45 CFR 155.315(f)(4)
[217] 45 CFR 155.315(f)(5)
[218] 45 CFR 155.315(f)(4)(ii)
[219] Rhode Island Medicaid Rules & Regulations, § 1308. 06
[220] 45 CFR § 155.315(f)(3)
[221] 45 CFR 155.320(a)-(f); 42 CFR 435.948(a)-(f); 42 CFR. 435.949(a)-(b); Rhode Island Medicaid Rules & Regulations, § 1303.05.01

for some eligibility factors, such as residency or pregnancy (except where the attestation is not reasonably compatible with available information).[222] For these eligibility factors, HealthSource RI will not verify the applicant's attestation against state or federal data sources unless such attestation does not appear reasonably compatible with information available to HealthSource RI.[223]

Customers must give HealthSource RI permission to obtain, use and share confidential information in compliance with HealthSource RI application policies. HealthSource RI must receive this consent to determine if an applicant is eligible for financial help. However, customers who decline to sign this consent and are already eligible for other benefits or programs will still receive access to those services.

For more information, please refer to HealthSource RI's application policies available on www.HealthSourceRI.com

C. Reasonable Compatibility Standards for Income

1) Overview of Reasonable Compatibility Standards

Eligibility determinations for individuals must be based, to the maximum extent possible, on self-attestation that is then verified by information obtained from federal and state electronic data sources.[224] When information obtained through these electronic data sources is reasonably compatible with an individual's attestation, the attestation is considered verified and will be used by HealthSource RI.

The following Table 2 summarizes Rhode Island's Reasonable Compatibility standards. These are discussed in greater detail below.

Table 2. Overview of Rhode Island's Reasonable Compatibility Standards

Attestation and Data Scenario	Reasonable Compatibility Standard
a. Both attestation and data are below Medicaid eligibility levels.	Reasonably Compatible: Individual is eligible for Medicaid.
b. Both attestation and data are above Medicaid eligibility levels.	Reasonably Compatible: Individual is ineligible for Medicaid and screened for APTC and CSR.
c. The attestation is lower than the data and the difference between the attestation and data is less than 25% and no more than $6,000.[225]	Reasonably Compatible: Eligibility based on attestation.
d. The attestation is lower than the data and the difference between the attestation and data is greater than 25% or $6,000.[226]	Not Reasonably Compatible: pursue reconciling discrepancy in accordance with the process outlined in Section A of this Chapter.

2) Attestation and Data are Both Below Medicaid Eligibility Levels

[222] Rhode Island Medicaid Rules & Regulations, § 1308.04
[223] Rhode Island Medicaid Rules & Regulations, § 1308.04.02-03
[224] 45 CFR 155.320(a)-(f); 42 CFR 435.945(a)-(b).
[225] "An attestation of income and data from electronic sources is considered reasonably compatible if the difference between the applicant's attestation and the data sources is less than 10%"; see Rhode Island Medicaid Rules & Regulations, §1308.06.03
[226] "An attestation of income and data on income sources are considered not reasonably compatible if the difference between the applicant's attestation and data sources is less than 10%"; see Rhode Island Medicaid Rules & Regulations, §1308.06.04

Attestation and data sources are reasonably compatible if the difference or discrepancy does not impact the eligibility of the applicant. In other words, even if there is a difference between what an individual says he or she earns or expects to earn and what the data shows, the data is considered reasonably compatible with the attestation if both the attestation and the data are both below Medicaid eligibility levels.

3) Attestation and Data are Both Above Medicaid Eligibility Levels

Attestation and data sources are reasonably compatible if they are both above the Medicaid eligibility levels. Under that scenario, the individual would be found ineligible for Medicaid and his/her eligibility would be screened for Advanced Premium Tax Credits (APTCs) and Cost Sharing Reductions (CSRs).

Example: An applicant attests that he/she makes $18,000 a year and the data shows that the individual earned $20,000 a year. Both the attestation and data are above Medicaid eligibility and are considered reasonably compatible for Medicaid eligibility. The individual is found ineligible for Medicaid. He/she/they will be screened for eligibility for APTC/CSR and need to verify income.

4) Attestation is Lower than Data and the Difference Between Attestation and Data is Less than 25%

An attestation of income eligibility and data sources is considered reasonably compatible if the difference between the applicant's attestation and the data sources is less than 25% (so long as difference is not greater than $6,000).[227] When data obtained by HealthSource RI is found reasonably compatible with the applicant's attestation, no further verification is required (including documentation) and the eligibility of the person will be based on their attestation.

Example: Applicant attests to an annual income of $25,000. HealthSource RI verifies the individual's attestation against data sources and shows an income of $27,000. The difference between the income the individual attested to and the data sources is reasonably compatible; the difference is less than 25% therefore no additional verification of income is required.

5) Attestation is Lower than Data and the Difference Between Attestation and Data is Greater than 25%.

An attestation of income eligibility and data sources is considered not reasonably compatible if the difference between the applicant's attestation and data sources is greater than 25%.[228]

Example: Applicant attests to an annual income of $25,000. HealthSource RI verifies the individual's attestation against data sources and shows an annual income of $52,000. The difference between the income the individual attested to and the data sources is not reasonable compatible because the difference is greater than 25%, the individual will need to verify their income.

D. Reasonable Explanations for Income Inconsistency

[227] Department of Health and Human Services; Center for Consumer Information and Insurance Oversight. "Annual Income Adjustment Threshold FAQ" July 21, 2016

[228] 45 CFR 155.320(c)(1)(vi)

When HealthSource RI finds an applicant's income attestation is not reasonably compatible with available data sources, HealthSource RI may accept a reasonable explanation.[229] The following chart is a non-exhaustive list of acceptable explanations when there is a discrepancy between an attestation of income and data sources. If the applicant provides one of these explanations, the applicant's eligibility will be based on their attestation and no further verification steps will be required of the applicant. Generally, for an explanation to be reasonable, it must be related to a life event resulting in a substantial change in income. Please see the following list of reasonable explanations for a discrepancy in income.

Reasonable Explanations for a Discrepancy in Income[230]	
• **Loss of job**	• **Fluctuating or inconsistent sources of income**
• **Decrease in hours/wages earned**	• **Income from capital gains**
• **Self-employed**	• **Income from dividends**
• **Do not file taxes**	• **Income from royalties**
• **Have not filed taxes yet**	• **Seasonal worker**
• **Homelessness**	• **Divorce or marriage**
• **Victim of domestic violence**	• **Death in family**
• **Victim of natural disaster**	• **Victim of identity theft**

E. Conditional Eligibility

If the applicant's attestation and HSRI's data verification are not reasonably compatible and, in the case of income eligibility, the applicant has been unable to provide a reasonable explanation, applicants will be given 90 days to submit satisfactory documentation to verify any outstanding eligibility elements.[231] This is referred to as conditional eligibility.

1) Temporary Eligibility for APTC/CSR

Customers who appear to be eligible for a Qualified Health Plan with financial help will be given temporary coverage during a 90-day reconciliation period. During this 90-day period, the applicant will receive coverage with financial help based on the individual's attested amount. However, if at the end of the 90-day period the individual is unable to resolve the inconsistency by submitting satisfactory documentation, HealthSource RI will adjust the eligibility for programs or assistance based on available data sources. This change may impact applicant's ability to stay in their current plan. In that case, the customer's plan would be canceled and the customer would have to re-enroll into a new plan, if eligible. A special enrollment period, as described in Chapter 3, will be provided to customers impacted in this way.

If an applicant attested to an incorrect income that consequently made them eligible for an amount of advanced premium tax credits (APTC) for which they were not actually eligible, the applicant will be responsible for repayment to the IRS of the difference in tax credits at the end of the year when filing taxes.

2) Temporary Eligibility for Medicaid/CHIP

[229] 45 CFR 155.320(c)(2)(i)(B); 42 C.F.R. 435.952(c).
[230] Rhode Island Medicaid Rules & Regulations, § 1308.07
[231] 45 C.F.R. 155.320(c)(3)(vi)(C)

Medicaid applicants with discrepancies other than citizenship or immigration status have 30 days provide satisfactory verification in order to proceed with the eligibility determination. An individual or dependent appearing to be Medicaid or CHIP eligible will not have temporary coverage during this 90-day reconciliation period. The only exception to this rule is where the individual or dependent is required to verify eligibility for citizenship or immigration status. Please refer to the most recent Medicaid Rules & Regulations with questions on temporary eligibility for Medicaid/CHIP.

3) Special Circumstance Exceptions

Individuals seeking APTC eligibility who meet certain special circumstances may be exempt from submitting documentary evidence to verify eligibility.[232] This evaluation will be conducted on a case-by-case basis by HSRI and may be available to applicants who can demonstrate an income-related hardship that prevents them from providing satisfactory documents, such as being a victim of domestic violence, a victim of a natural disaster, or being homeless.[233] These requests must be made by calling the HealthSource RI Contact Center.

4) Good Faith Extension

For QHP, APTC and CSR eligibility, the 90-day period to provide satisfactory documentary evidence may be extended, on a case-by-case basis as determined by HSRI, if the individual demonstrates a good faith effort to secure the documents and provides a reasonable explanation as to why the documents have not yet been provided. HealthSource RI will consider any request for a good faith extension on a case-by-case basis and must be requested by the customer through the contact center. Generally, good faith extensions may be extended to individuals whose efforts to comply with information requests were frustrated by a lack of available data, physical or technical difficulties in accessing systems housing necessary documentation, or where there is a lack of available sources with which to verify data.

F. Satisfactory Documentation

During the reconciliation process, applicants will be asked to submit satisfactory documentation to verify eligibility. The following charts summarize acceptable documentation when verifying eligibility.

Identity (First Name/Last Name)[234]
• Birth Certificate or hospital birth records • U.S. Passport • Naturalization Certificate • Social Security Card • Driver's License • State Issued Photo ID • Federal, State, or Local government issued ID • School Photo ID • Employment Authorization Card

[232] 45 CFR S. 155.315(g)
[233] 45 CFR S. 155.315(g)
[234] HealthSource RI Application Field Inventory, Tab B: Accepted Documentation.

- Permanent Resident Card
- Voter Registration Card

Social Security Number[235]

- Naturalization Certificate
- Social Security Card
- Military Service Records
- Alien Card (I-155)
- Employment Authorization Card (I-688B)
- Social Security Records
- Federal tax return showing SSN

Date of Birth[236]

- Birth certificate
- U.S. Passport
- Naturalization Certificate
- Social Security Card
- Driver's License
- State Issued Photo ID
- Social Security Records
- Native American Tribal documentation
- Baptismal Certificate
- Voter Registration Card
- Confirmation Papers
- Marriage License
- State/Federal Census Record
- Life Insurance Policy
- Immigration Papers
- School Records
- Military Service Records
- Physician Records
- Hospital Birth Records
- RSDI Award Letter if DOB of child is included
- Adoption Records
- Affidavit of a Third Party

Residency[237]

- Rent Receipt
- Letter from Landlord
- Lease
- Mortgage Papers
- Utility Bill
- Property Tax Bill
- Home Insurance Bill
- Letter from Person Whom Applicant Pays Room and Board
- Mortgage Books/Records

[235] HealthSource RI Application Field Inventory, Tab B: Accepted Documentation.
[236] HealthSource RI Application Field Inventory, Tab B: Accepted Documentation; Rhode Island Medicaid Policy, Verification of Age, 0328.05.05.
[237] HealthSource RI Application Field Inventory, Tab B: Accepted Documentation.

- Sewer and Water Bills
- Non-Heating Utility Bills
- Telephone Bills

Income

- Pay stubs representative of the last four (4) weeks of income
- Earnings Statement
- Employment Letter
- Book Keeping Records
- Property Unit Proof
- Owner Occupied Proof
- Monthly Rental Income Proof
- Mortgage Breakdown Proof
- Income Tax Returns
- Reports from Social Security Veteran's Administration and other agencies
- When the applicant is unable to obtain the information requested Departmental forms (Wage Report, AP-50; Bank Clearance, AP-91; Clearance with VA, AP-150 and AP-151) are used.

Access to other coverage

- Letter from health insurer including coverage termination date
- Statement of health benefits that provides confirmation of health coverage and expiration dates
- Letter from Veterans Administration that provides clarification of scope of access to coverage, confirmation of health coverage with and expiration dates
- Letter from Peace Corps or AmeriCorps that provides clarification of scope of access to coverage, confirmation of health coverage and expiration date or that provides clarification of scope of access to coverage
- Letter or statement of Medicare or Medicaid benefits that proves clarification of scope of access to coverage, confirmation of health coverage and expiration dates
- Letter or statement of Medicaid or Children's Health Insurance Program (CHIP) benefits that provides clarification of scope of access to coverage, proves confirmation of health coverage and expiration dates

Death

To demonstrate one is not deceased:

- For an adult applicant that must provide data to demonstrate that he or she is not deceased, the individual must present, in person, with a valid photo ID at the HSRI Drop Off Center.
- For a child applicant who does not possess a valid photo ID, a recent document will be accepted. A recent document is defined as a letter, form, or official record from a physician, school or day care dated within the past three months. Documents can be uploaded, faxed, or the letter can be mailed, or brought to the HSRI Drop Off Center.

To demonstrate one is deceased:

- Death certificate
- Letter from funeral home
- Obituary

Incarceration

To demonstrate one is not incarcerated:

- Discharge ID (only valid for 1 month following release date)
- Discharge records

- Dated and signed letter from parole or probation officer with a seal or stamp from the Department of Corrections
- Adult applicants may present, in person, with a valid photo ID at the HSRI Drop Off Center

Citizenship[238]

Primary Evidence: The following evidence must be accepted as satisfactory documentary evidence of <u>both identity and citizenship</u>

- A U.S. Passport
- Report of birth abroad of U.S Citizen
- A Certificate of Naturalization
- A Certificate of U.S. Citizenship
- A valid State-issued driver's license, if the State issuing the license requires proof of U.S. citizenship or a social security number to issue a license. This is known as an enhanced driver's license (Note: Rhode Island driver's license does not fulfill this requirement). As of 2017 the only states offering these IDs are Michigan, New York, Vermont and Washington.
- Documentary evidence issued by a federally recognized Indian Tribe

Secondary Evidence: Only if the above documents are not available, the applicant can provide two of the following as secondary evidence:

One of the following documents to <u>show citizenship</u>:	**PLUS One of these documents to <u>prove identity</u>:**
A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam, the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986 (CNMI local time)).	For individuals 16 years of age or older, any of the following Identity documents (described in 8 CFR 274a.2(b)(1)(v)(B)(1)):
Evidence of birth in Puerto Rico, the U.S. Virgin Islands or the Mariana Islands after they became part of the United States or an applicant's statement that they were resident in one of these locations when they became part of the United States.	A driver's license or identification card containing a photograph, issued by a state
At state option, a cross match with a State vital statistics agency documenting a record of birth.	School identification card
A Certification of Report of Birth	Voter's registration card
A Report of Birth Abroad of a U.S. Citizen	U.S. military card or draft record
A Certification of birth issued by the Department of State	Identification card issued by the Federal, State or local government
A U.S. Citizen I.D. card	Military dependent's identification card
A Northern Mariana Identification Card (I-873)	U.S. Coast Guard Merchant Mariner card
A final adoption decree showing the child's name and U.S. place of birth	For children under age 19, a clinic, doctor, hospital or school record, including preschool or day care records
Evidence of U.S. Civil Service employment before June 1, 1976	Two documents containing consistent information that corroborates an applicant's identity. Such

[238] 42 C.F.R. 435.407(a)-(d)

Citizenship[238]	
	documents include, but are not limited to, employer identification cards, high school and college diplomas (including high school equivalency diplomas), marriage certificates, divorce decrees and property deeds or titles
U.S. Military Record showing a U.S. place of birth	Finding of identity from a Federal or State governmental agency including, but not limited to, public assistance, law enforcement, internal revenue or tax bureau or tax bureau or corrections agency, if the agency has verified and certified the identity of the individual.
A data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizens	A finding of identity from an Express Lane Agency
Documentary evidence of Child Citizenship Act status for adopted or biological children born outside the United States	If the applicant does not have any of the above listed documents, the applicant may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the applicant's identity
Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth	
Official religious record recorded in the U.S. showing that the birth occurred in the U.S.	
School records including pre-school, Head Start and daycare, showing the child's name and U.S. place of birth	
Federal or State census record showing U.S. citizenship or a U.S. place of birth	
If the applicant does not have one of the documents listed above, he or she may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship and that contains the applicant's name, date of birth and place of U.S. birth. The affidavit does not have to be notarized	
A clinic, doctor, hospital, or school record, including preschool or day care records (for children under 19 years old)	

Immigration Status[239]
• Birth Certificate • Baptismal Certificate • U.S. Passport • Naturalization Certificate • Military Service Records • Alien Resident Card (I-155) (also known as a Green Card) • Employment Authorization Card (I-688B) • For recent arrivals, a temporary I-551 stamp in a foreign passport or on USCIS Form I-94 • Unexpired Re-entry Permit (Form I-327) • Forms AR-3 and AR-3a, Alien Registration Receipt Card • USCIS Form I-94 with stamp showing admission under 203(a)(7) of the INA, refugee-conditional entry • I-94 Arrival/ Departure record • I-94W Nonimmigrant Visa Waiver Arrival/Departure record • USCIS Form I-688B (or USCIS employment authorization card) annotated 274a.12(a)(3); • USCIS Form I-766 annotated A3. • For lawful permanent residents who are victims of domestic violence - IRS form I551 or I551B coded IB1 through IB3, IB6 through IB8, B11, B12, B16, B17, B20 through B29, B31 through B33, B36 through B38, BX1 through BX3, BX6, BX7 or BX 8 • For victims of domestic violence petitioning for legal status who are considered as "qualified aliens" under PROWORA - IRS Form 797 showing an approved 1-360 or 1-13 self-petitioning as a spouse or child of a U.S. citizen or lawful permanent resident; OR USCIS Form 797 showing a Notice of Prima Facie Determination • USCIS Form I-94 with date of admission and annotated with unexpired status as listed in Section 0304.05.45.05 • Dated USCIS letter or court order indicating a lawfully residing status listed in Section 0304.05.45.05 • An unexpired USCIS employment authorization document (I-688-B) annotated with status code • Applicants for asylum: I-94, I-589 on file, I-688B coded 274a.12(c)(8) • Applicants for suspension of deportation: I-94, I-256A on file, I-688B coded 274a.12(c)(10) • Non-citizens granted stays of deportation by court order statute or regulation or by individual determination of USCIS whose departure the USCIS does not contemplate enforcing: letter or Granted a stay of deportation, I-688B coded 274.12(c)(12) • Non-citizens granted suspension of deportation pursuant to Section 244 of INA (8 USC 1254) whose departure the USCIS does not contemplate enforcing: letter/order from the immigration judge and a Form I-94 showing suspension of deportation granted • Non-citizens residing in the U.S. pursuant to an Order of Supervision: USCIS Form I-220B, I-688B coded 274a.12(c)(18) • Temporary Protected Status: I-94 "Temporary Protected Status" and/or I-688B employment authorization coded 274a.12(a)(12) • Deferred Enforced Departure: Letter from USCIS; I-688B coded 274a.12(a)(11)

[239] Rhode Island Medicaid Policy, Immigration Eligibility, 0304.05.15-0304.05.85.05.

- Family Unity: USCIS approval notice, I-797, and/or I-688B coded 274a.13
- Non-citizens granted deferred action status: Letter indicating that the non-citizen's departure has been deferred and/or I-688B coded 274a.12(c)(14)
- Non-citizens who have filed applications for adjustment of status whose departure the USCIS does not contemplate enforcing: Form I-94 or I-181 or passport stamped with either of the following: "adjustment application" or "employment authorized during status as adjustment applicant"; and/or I-688B coded 274a.12(c)(9)
- USCIS Form I-94 annotated with stamp showing entry as a refugee under Section 207 of the INA and date of entry
- USCIS Form I-688B (or USCIS Employment Authorization Card) annotated 274a.12(a)(3)
- USCIS Form I-766 annotated A3
- USCIS Form I-571
- USCIS Form 551 (Resident Alien Card) coded RE-6, RE-7,RE-8, or RE-9
- USCIS Form I-94 annotated with stamp showing a grant of asylum
- Grant letter from the Asylum Office of the USCIS
- USCIS Form I-688B annotated with 274a.12.(a)(S)
- USCIS Form I-766 annotated
- Order from Immigration Judge granting asylum
- Order from an Immigration Judge showing the date of a grant of deportation withheld under Section 243(h) of the INA
- USCIS Form I-688B (or USCIS employment authorization card) annotated 274a.12(a)(10)
- USCIS Form I-766 annotated A10
- USCIS Form 551 with codes CU6, CU7, or CH6
- Unexpired temporary I-551 stamp in a foreign passport or USCIS Form I-94 with codes CU6 or CU7
- USCIS Form I-94 with stamp showing the individual paroled as a Cuban/Haitian Entrant under Section 212(d)(5) of the INA
- An USCIS Form I-94 annotated with a stamp showing grant of parole under 212(d)(5) of the INA and a date showing granting of parole for at least one (1) year is acceptable verification of this status
- ORS issues a certification letter to adults and a letter of benefit eligibility pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000 to children under eighteen (18) years of age: For adult, the ORS certification letter is proof of qualified non-citizen status; For children under age eighteen (18), the ORS letter of benefit eligibility is proof of qualified non-citizen status

American Indian or Alaskan Native

- Church or baptismal record
- Family Bible
- Federal, State, or Local Government-Issued ID
- Hospital Birth Records
- Other Date of Birth Verification
- Other documentation showing SSN
- Other identity document
- Qualifying school record showing US birth
- School photo ID
- SN-5028 Receipt for Application for a Social Security Number
- SS-5 Application for a Social Security Card
- Voter Registration card
- Official military records showing US birth

Chapter 8: Mid-Year Eligibility Updates and Renewals

A. Overview of Mid-Year Updates and Redeterminations

Individuals and households determined eligible for enrollment in Insurance Affordability Programs (IAPs) – Medicaid, RIte Care, Advanced Premium Tax Credits (APTC), Cost Sharing Reductions (CSR) – and Qualified Health Plans (QHPs) must undergo a redetermination of eligibility every 12 months. If new information impacting eligibility becomes available to the State – either reported by the individual or accessed through other data sources – during the 12-month period, the individual's account must be updated. Multiple outcomes may result from an annual redetermination or the receipt of information requiring an account update. For example, a household may:

- Remain eligible for the same program in the same eligibility category;
- Remain eligible for the same program and eligible for a different category or cost-sharing amount;
- Become eligible for another program entirely; or
- Become ineligible for coverage.

If a household remains eligible for the same program, the redetermination date remains the same. If the household becomes ineligible under a current program, HealthSource RI will assess eligibility for other IAPs.

In addition to an annual redetermination, QHP customers will have routine data checks performed on customer accounts to ensure there have been no changes that may impact a customer's eligibility to purchase health insurance from HealthSource RI, or that may impact that customer's eligibility for existing financial assistance in the form of APTC's or CSR's. These constitute "Mid-Year Eligibility Updates" and are described in further detail below.

The purpose of this Chapter is to describe the rules and procedures governing IAP and QHP eligibility updates and redeterminations.

B. Mid-Year Eligibility Updates

1) Mid-Year Eligibility Updates

The following outlines how HealthSource RI becomes aware of new information impacting customer eligibility. Processes may differ depending on whether the information is self-reported or is accessed through external data sources, as well as if the household is enrolled in MAGI Medicaid/RIte Care or QHP with financial assistance.

a) Information Reported by Individuals

Households must report any change affecting eligibility for IAPs and QHPs.[240] These include changes to:

[240] 45 CFR 155.330(b)(1)

- Citizenship, status as a national, or lawful presence;
- Incarceration status;
- Residency;
- Income;
- Pregnancy;
- Household composition (e.g., a recent birth, death, or adoption); and
- Access to other sources of health coverage.

Individuals receiving Medicaid and CHIP must report changes to any of the above within 10 days,[241] while those enrolled in a QHP with or without financial assistance, must report within 30 days of such change.[242] Individuals may report changes:

- **Online.** Through their secure user account at www.HealthSourceRI.com;
- **By phone**. By calling the HealthSource RI Contact Center at **(855) 712-9158**;
- **By mail**. At this address: HEALTHSOURCE RI, HZD MAILROOM , 74 WEST ROAD STE 800, CRANSTON, RI 02920-8412
- **In person**. At the HealthSource RI Walk-In Center at 401 Wampanoag Trail in East Providence.

If an individual reports a change affecting eligibility, DHS and EOHHS will update the account for Medicaid and CHIP eligibility,[243] and HealthSource RI will update the account regarding eligibility for a QHP, APTCs, and CSRs.[244] Customer reported changes may be shared across programs.

EOHHS, DHS and HealthSource RI provide periodic notifications to households regarding the obligation to report changes. These may be sent by mail, electronically via the household's online account, or both, depending upon the communication preference selected by the household. The household may change their preference to receive mail or electronic notifications by accessing their online account or by calling the HealthSource RI Contact Center at **(855) 712-9158**.[245]

If a QHP enrollee did not request to be considered for IAP eligibility when the customer applied for coverage (i.e., indicated he or she was not interested in financial assistance), the enrollee is not required to report any information related to IAP eligibility, but is still required to report changes impacting eligibility for HealthSource RI coverage, for example change in address or incarceration.[246]

EOHHS, DHS and HealthSource RI will verify any information reported by the individual following the standard verification processes used at application, as described in detail in Chapter 7.[247]

b) Medicaid/CHIP Eligible Individuals*:* Information Identified through Data Matching

[241] 42 CFR 435.916(c)
[242] 45 CFR 155.330(b)(4)
[243] 42 CFR 435.916(c)
[244] 45 CFR 155.330(a)
[245] 45 CFR 155.330(c)(2)
[246] 45 CFR 155.330(b)(2)-(3)
[247] 45 CFR 155.330(c)(1)

For Medicaid/CHIP eligible individuals, OHHS, DHS and HealthSource RI will examine data sources periodically to identify changes related to eligibility. The frequency of these checks will vary by eligibility and data source.

Table 1. Data Sources Reviewed To Identify Changes Related To Eligibility

Eligibility Factor	Data Source	Frequency
Income	State Wage Information Collection Agencies (SWICA)	Data refreshed quarterly and accessed real-time
	Unemployment	Data refreshed weekly and accessed real-time
Death	Social Security Administration, Local Departments of Health[8]	Real-time to Federal Hub SSA data. DOH State data refreshed weekly & accessed real-time
Incarceration	Department of Corrections, Social Security Administration	DOC state data refreshed weekly & accessed real-time. Real-time access to Federal Hub SSA incarceration data.
Access to other Health Insurance	Non-ESI (Employer Sponsored Insurance) MEC (Minimum Essential Coverage) checks the following federal data: Medicare, Medicaid, CHIP, Tricare, Peace Corps, VHA (Veterans), and BHP	Real-time to Federal Hub SSA data.
	Self-Report	Done by customer during the application process

c) APTC/CSR/QHP Eligible Individuals: Information Identified through Data Matching

For APTC/CSR/QHP eligible individuals, EOHHS, DHS and HealthSource RI will examine a variety of data sources periodically to identify any changes related to:[248]

- Death;
- Incarceration status; and
- Eligibility for Medicare, Medicaid or CHIP for individuals receiving tax credits or cost-sharing reductions (CSRs).

i) Updated Information Related to Financial Eligibility Criteria Including Income, Family Size or Family Composition

The account update process for information related to income, family size or family composition (which could

[248] 45 CFR 155.330(d)

have an impact on the amount of APTCs and CSRs for which a household is eligible) differs slightly from the process for updating nonfinancial criteria. If HealthSource RI identifies inconsistency of information relating to income, family size or family composition for QHP-eligible households[249] a notice will be sent to the household that will indicate which members of the household need to confirm information along with a list of acceptable documents to verify that information (as found in Chapter 7). The household has 90 days from the date of the notice to respond and either confirm the information or contest any inaccuracies.

If the individual responds within the 90-day period to contest the accuracy of the information, HealthSource RI will reconcile the inconsistency according to the process outlined in Chapter 7. If the household does not respond within 90 days, HealthSource RI will use the information from existing data sources to update the household's eligibility.

ii) Updated Information Related to Nonfinancial Eligibility Criteria Including Death and Incarceration

If HealthSource RI identifies updated information relating to death or other nonfinancial eligibility factors (all factors other than income, family size or family composition)[250] HealthSource RI will send a notice to the household, listing the updated information needed. The customer will have 90 days from the date of the notice to contest any inaccuracies.

If the customer responds within the 90-day period contesting the accuracy of the information, EOHHS, DHS and HealthSource RI will reconcile the inconsistency according to the process outlined in Chapter 7. If the individual does not respond, the State will use the identified information to update his or her eligibility. It is important to note that updates to an individual's eligibility may have an impact on other household members' coverage.

2) Noticing Related to Reporting Changes

Individuals are notified of their responsibility to report changes within 10 days of the change for Medicaid and CHIP, and within 90 days of the change for APTCs, CSRs, and QHP. Individuals receive messages about their obligation to report changes in multiple HealthSource RI notices, including those relating to exemption determination, annual open enrollment, QHP enrollment and disenrollment, Medicaid termination, and eligibility determinations. Additionally, a "periodic reminder for change reporting" is sent to customers via mail or uploaded to their account, depending upon the communication preference they selected, throughout the year. Customers should report all changes as soon as possible in order to avoid any unintended consequences for their coverage.

3) Coverage Effective Dates for Changes

a) Medicaid/CHIP Individuals

If the reported change makes an individual ineligible for Medicaid and/or CHIP, the individual will be notified at

[249] 45 CFR 155.330(e)(3)
[250] 45 CFR 155.335(e)(2)(i)

least 15 days before his or her coverage is canceled, or according to the most recent Medicaid Rules & Regulations. If the individual disagrees with the change in eligibility, he or she may request a hearing and aid pending according to the process described in Chapter 9 while awaiting the hearing date.[251]

b) APTC/CSR/QHP Individuals

In general, changes to APTC, CSR, and QHP-eligible individuals and households identified by the 23rd of the month are effective the first day of the month following the date of the notice.[252] However, there are exceptions to this rule depending on the nature of the change in eligibility factor and whether the change affects the customer's level of financial help.

Table 2. Changes in Household Status & Corresponding New Coverage Effective Dates*

Change	Coverage Effective*
Impacts Premiums or Enrollment[253]	First day of the month following that in which the HealthSource RI is notified of the change.
Birth, Adoption, Placement for Adoption or Placement in Foster Care[254]	Date of birth, adoption, placement for adoption or placement in foster care.
Marriage or Loss of Minimum Essential Coverage[255]	First day of the following month.
Newly eligible for Medicaid or CHIP[256]	QHP coverage terminates the day before such coverage begins. In the case where a customer becomes eligible for Medicaid or CHIP mid-month, the customer's QHP coverage will continue for the duration of that month in which they became eligible.

**For coverage to be effective as of the time frames provided in the table above, the customer must first report the change, make a plan selection, and make the first premium payment, all by the 23rd of the month.*

If a change results in a decrease in Advanced Premium Tax Credits (APTCs) or a change in Cost Sharing Reductions (CSRs), and the household notifies HealthSource RI of the change, or the redetermination notice is sent after the 23rd of the month, the change may not be effective until the first day of the following month.[257]

If the reported change results in an APTC or CSR eligible household becoming newly eligible for Medicaid or CHIP, then the individual or household will be enrolled in Medicaid. Those who enroll in Medicaid will also have the opportunity to be evaluated for retroactive coverage dating back to the first of the month of the date of application through DHS. As noted in the table above, if a customer is actively enrolled in a QHP plan and found eligible for Medicaid coverage dating back to the first of the month, the customer will have one month

[251] 42 CFR 431.211
[252] 45 CFR 155.330(f)(1)(i)
[253] 45 CFR 155.330(f)(1)(iii)
[254] 45 CFR 155.330(f)(4)
[255] 45 CFR 155.330(f)(4)
[256] 45 CFR 155.430(d)(iv)
[257] 45 CFR 155.330(f)(3)

where the customer has both QHP and Medicaid coverage.

Table 2. Overview of Account Update Processes for Medicaid/CHIP/APTC/CSR Individuals

Program Eligibility Prior to Change Report	Eligibility Impact of New Information	Specific Change to Eligibility	Documentation Issued to Consumer	Coverage Effective Date
Medicaid/CHIP/ APTC/CSR	No impact on eligibility	n/a	Notice acknowledging updated account information and indicating no changes to individual's coverage	No change to next anticipated annual redetermination date
Medicaid/CHIP	Change in eligibility (prior to termination of Medicaid/CHIP eligibility, must conduct ex parte review and check for all bases of eligibility)	Eligibility for Extended Family Planning Program 60 Days Postpartum	To be determined – policy discussion ongoing	To be determined – policy discussion ongoing
		Different Medicaid /CHIP category	Notice acknowledging updated account information and change in Medicaid/CHIP eligibility category	No change to next anticipated annual redetermination date
		Ineligible for Medicaid/CHIP, Eligible for APTC/CSR	Combined notices with Medicaid/CHIP eligibility termination, right for aid continuing, eligibility determination for APTC/CSR	New annual redetermination date for next open enrollment period
		Ineligible for Medicaid/CHIP, Eligible for QHP	Combined notice with Medicaid/CHIP eligibility termination, right for aid continuing, eligibility determination for QHP	New annual redetermination date for next open enrollment period
		Ineligible for all IAP/QHP	Combined notice with Medicaid/CHIP eligibility termination, right for aid continuing, eligibility denial for other IAPs/QHP	n/a
APTC/CSR	Change in eligibility	Different APTC/CSR level	Notice acknowledges updated account information and indicates there are no changes to individual's	No change to next anticipated annual redetermination date

Program Eligibility Prior to Change Report	Eligibility Impact of New Information	Specific Change to Eligibility	Documentation Issued to Consumer	Coverage Effective Date
			coverage	
		Ineligible for APTC/CSR, Eligible for Medicaid/CHIP	Combined notice with APTC/CSR eligibility termination, eligibility determination for Medicaid/CHIP	New annual redetermination date
		Ineligible for APTC/CSR, Eligible for QHP	Combined notice with APTC/CSR eligibility termination, eligibility determination for QHP, eligibility denial for Medicaid/CHIP	No change to next anticipated annual redetermination date
		Ineligible for all IAP/QHP	Combined notice with APTC/CSR eligibility termination, eligibility denial for Medicaid/CHIP	N/A

C. Annual Redeterminations

Eligibility for IAPs[258] must be re-determined every 12 months.[259,260,261] EOHHS, DHS and HealthSource RI must make the redetermination, if possible, based on information available to the state from the individual's account, or other more current sources (such as electronic databases), and without requiring in-person interviews.[262] If EOHHS, DHS and HealthSource RI do not have enough information to Re-determine eligibility, they must reach out to the individual and receive an adequate response to continue coverage.

The following information outlines procedures for the annual redetermination process. Procedures vary depending on whether individuals are currently enrolled in Medicaid/RIte Care or enrolled in a QHP with (or without) APTCs or CSRs.

1) Medicaid/CHIP Eligible Individuals Redetermined by EOHHS/DHS

For Medicaid/CHIP eligible individuals, an *ex parte* process is used. If the State has enough information available to redetermine an individual's or household's eligibility for Medicaid or CHIP, the redetermination process may proceed. All bases of Medicaid eligibility must be considered.

[258] Assuming initial eligibility determined using MAGI-based income methods
[259] 42 CFR 435.916
[260] 42 CFR 457.343
[261] 45 CFR 155.335(a)
[262] Any data bases accessed by the agency under 42 CFR 435.948, 42 CFR 435.949 and 42 CFR 435.956

If EOHHS or DHS have enough information to re-determine that an individual or household is eligible for coverage, they will proceed to do so without requiring additional information.

If EOHHS or DHS are unable to renew an individual's eligibility for Medicaid/RIteCare using information in the customer's account and other more current sources, either because available information is insufficient to make a redetermination or existing information indicates a customer is ineligible for coverage, the customer will receive a renewal form. The customer must complete and submit the renewal form according to the most recent Medicaid Rules & Regulations.

2) APTC- & CSR-Eligible Individuals & Households

For APTC and CSR eligible individuals and households, HealthSource RI will initiate a renewal process prior to the Annual Open Enrollment Period each year. Please refer to Chapter 2, section F. Automatic Renewal, for more information.

a) Annual Redetermination Notice

HealthSource RI sends an annual redetermination notice[263] to each primary account contact to announce the renewal process and dates for the Annual Open Enrollment Period.

The renewal notice is sent as a single, coordinated communication with the annual open enrollment notice containing:

- Dates of the upcoming open enrollment period;
- Description of the annual redetermination and renewal process;
- Any applicable requirement to report changes to information affecting eligibility and the timeframe and channels through which to do so;
- The last day by which a plan selection may be made for coverage to be effective as of January 1 of the upcoming coverage year and the payment deadline for the same;
- A brief description of the premium tax credit calculation methodology and a reminder regarding the reconciliation process; and
- A clear statement of what action, if any, must be taken by the customer to renew coverage and avoid a disruption in coverage between one year's coverage end date and the upcoming year's start date;

Required Authorization to Access Tax Return Data
For APTC and CSR eligible individuals and households, HealthSource RI must obtain authorization for the release of tax return information in order to access updated financial information and re-determine each individuals eligibility for financial help. The individual grants such consent during the application process and may provide an authorization for up to 5 years. This consent may be found on HealthSource RIs website.[264] The individual may also provide consent for a designated authorized representative to obtain access to this information for the purposes of representing them at a hearing. If HealthSource RI does not have a valid authorization to access tax data from an individual, it may only conduct a redetermination for QHP eligibility

[263] 45 CFR 155.335(c)

[264] available at https://healthsourceri.com/application-policies/

without financial help. Tax data is essential to the determination of eligibility for tax credits and cost sharing reductions. HealthSource RI may not proceed with the redetermination for IAP eligibility until the individual authorizes access to tax data.

b) Eligibility Redetermination

Each year, HealthSource RI will send a notice to existing customers encouraging them to make updates to pertinent information that may impact their eligibility for coverage and affordability assistance (e.g., family size, income, incarceration, immigration). The application process used during a renewal will be abbreviated and will be pre-populated with current year application data to the extent possible.[265]

c) Coverage Effective Data

Assuming all steps required of the applicant are taken in accordance with appropriate deadlines, a redetermination for coverage may be effective on the first day of the following coverage year.[266]

D. Enrollment Reconciliation

Pursuant to 45 CFR §155.400(d), HealthSource RI is required to reconcile enrollment records with all participating health insurance companies and HHS on a monthly basis. Because The Centers for Medicare and Medicaid Services (CMS) pays APTCs and CSRs to health insurance companies on the basis of the enrollment files, it is critical that entities' enrollment data is reconciled. In addition, the enrollment data retained by HealthSource RI is used as the basis for annual generation of Form 1095-A tax data for customers. Accurate enrollment information allows CMS to make correct payments for APTCs and CSRs. It also supports quality assurance that the data used for analytics and metrics are accurate and that billing and enrollment systems are also correct.

1) Enrollment Data Reconciliation Process

When customers enroll in coverage through HealthSource RI or make changes to their coverage, HealthSource RI sends an enrollment transaction to the relevant health insurance company. To ensure the accuracy and completeness of the information and to maintain consistent information between health insurance companies and HealthSource RI, a process called "enrollment data reconciliation" is used. At least monthly, HealthSource RI uses an automated monthly reconciliation process to compare billing and enrollment systems data with health insurance company data.

2) Resolution of Enrollment Discrepancies

HealthSource RI will resolve discrepancies identified through the enrollment reconciliation process. Resolution will include correction of erroneous billing or plan enrollment.

a) Over-Billed Premiums

[265] Any information reported by a customer will be verified using the processes outlined in 45 CFR §§155.315 and 155.320.
[266] 45 CFR 155.335(i)-(j)

HealthSource RI may retroactively correct any over-billed premium amount for an erroneously high premium amount. HealthSource RI must, within a reasonable time of the discovery of the over-billing, credit the over-billed premium to the enrollees' accounts, refund the over-billed amount to the enrollees, or use a combination of both solutions.

b) Under-Billed Premiums

The term "under-billed premium" refers to a circumstance where HealthSource RI bills an enrollee an erroneously low premium amount (or does not bill the enrollee at all). HSRI may, within a reasonable time of discovery of under-billing, generate a corrected invoice and duly update the customers' account balances.

Chapter 9: Individual Eligibility and Shop Appeals

A. Overview of HealthSource RI Complaints and Appeals Process

HealthSource RI aims to provide an integrated and customer-centered complaints and appeals process. To the maximum extent possible, the process enables customers to resolve issues promptly and informally, with the goal of avoiding the need for a formal hearing while also supporting a customer's right to pursue a hearing where desired.[267] MAGI, Medicaid and HealthSource RI appeals are handled in a coordinated manner across HealthSource RI and the Executive Office of Health and Human Services (EOHHS).[268]

Applicants and enrollees are entitled to a hearing to appeal the following actions:[269]

- Whether they are eligible to buy a Marketplace plan, including a Catastrophic health insurance plan;[270]
- Whether they can enroll in a Marketplace plan outside the regular open enrollment period;[271]
- Whether they are eligible for lower costs based on their income;[272]
- The amount of savings they are eligible for;[273]
- A redetermination of eligibility, including the amount of APTCs and level of CSRs;[274]
- Whether they were properly terminated or dis-enrolled from a QHP;[275]
- Whether they are eligible for an exemption from the requirement to have health insurance;[276] and
- Whether employers or employees are eligible for the SHOP Exchange;[277]

HealthSource RI administers Large Employer Appeals,[278] including whether the employer provides minimum essential coverage through an employer-sponsored plan or whether that employer provided coverage that is unaffordable.

B. Complaints Process Rules

The formal appeals process may not always be the most appropriate nor the most efficient venue for all customer issues. Many questions, concerns and disputes can be informally resolved without the need for a hearing. In many cases, HealthSource RI will be able to resolve a customer's appealable issue prior to the customer's scheduled hearing date. Customers are therefore encouraged to report questions and concerns first by calling, mailing or faxing the HealthSource RI Contact Center, or by logging in to their account online and submitting a complaint. Customers may submit a complaint by logging in to their account, choosing the "Tasks" tab on the Home Page, and then clicking "File a complaint" in the Tasks tab.

[267] 210-RICR-10-05-2.
[268] 210-RICR-10-05-2.
[269] 220-RICR-90-00-1.4(A)(12)
[270] 220-RICR-90-00-1.4(A)(8)
[271] 220-RICR-90-00-1.4(A)(8)
[272] 220-RICR-90-00-1.4(A)(8)
[273] 220-RICR-90-00-1.4(A)(8)
[274] 220-RICR-90-00-1.4(A)(8)
[275] 220-RICR-90-00-1.4(A)(8)
[276] 220-RICR-90-00-1.4(A)(13)
[277] 220-RICR-90-00-1.4(A)(29)
[278] 220-RICR-90-00-1.4(A)(20)

Complaints may be submitted:

- by phone at 1-855-840-4774 ;
- by mail at **HealthSource RI, Hazard Building Mailroom, 74 West Road, Suite 500, Cranston, RI 02920-8409;**
- by fax to the HealthSource RI Customer Support Center at **401-223-6317**; or
- by accessing their account online, choosing the "Tasks" tab on the Home Page, and clicking "File a Complaint".

In the event HealthSource RI is able to accommodate a customer's request to retroactively change the customer's coverage start date or eligibility, it may take up to 30 days to process the request. Accordingly, once a customer has requested a change to his or her coverage, the customer will be responsible for paying for the requested coverage as long as the request is processed within 30 days of approval.

C. Appeals Process Rules

The following outlines the rules governing the EOHSS appeals processes, highlighting any differences between the individual eligibility and SHOP appeals processes.

1) Notice of Appeal Rights

Customers are provided information about their appeal rights in their application packet and upon their eligibility determination. Every Eligibility Decision Notice informs customers of their right to a hearing, procedures by which to request a hearing, the right to designate an authorized representative or his or her choosing and the circumstances under which aid may be continued pending an appeal.[279] Each Eligibility Decision Notice also includes an appeal request form (see Appendix for a sample copy of the Appeals Form). Medicaid notices must be sent at least 15 business days before the date of action,[280] and include a statement of the action to be taken by the agency and the effective date of such action, reasons for taking the action, sources of law or regulation that support the action, and the customer's right to request a state Medicaid agency hearing.[281] Notices must explain that the outcome of an appeals decision may result in a change of eligibility for other household members and that such a change may be treated as a redetermination.[282]

The same requirement to provide a notice of appeal rights exists for employers and employees applying for eligibility in the SHOP Exchange.[283] The notice of appeals rights must be included in a notice of denial issued to an employer and employee. Employers and employees may both appeal the failure of the SHOP Exchange to make a timely eligibility decision.[284] If an employer does not include an employee on the Employee Census, the employee will not be eligible for the SHOP Exchange and will not receive a denial of eligibility from the SHOP Exchange.[285]

[279] 42 CFR 431.206 and NPRM; 42 CFR 431.210 and NPRM; 45 CFR 155.515.
[280] Rhode Island Medicaid Rules & Regulations Ch. 0302(D)(1)
[281] 42 CFR 431.211 and NPRM; 42 CFR 431.210 and NPRM.
[282] 45 CFR 155.515(b).
[283] 45 CFR 155.740(e)(2).
[284] 45 CFR 155.740(c)(2) & (d)(2).
[285] 45 CFR 155.710(e).

2) Request for Appeal

Customers must request an appeal within **30 days** of the date of the notice of eligibility determination.[286] The request must be filed or postmarked within the 30-day period. The customer is presumed to have received the notice of action 5 business days after the date on the notice unless the customer can show that he or she did not receive it within that 5-day day period.

Requests for Appeals may be submitted:

- In-person to the HealthSource RI Contact Center or the DHS field office;
- By telephone through the Contact Center;
- By fax to the HealthSource RI Customer Support Center;
- By U.S. Mail to the address indicated on the appeals request form;
- Online by accessing the user's account, choosing the "Tasks" tab on the Home Page, and then clicking "File an Appeal".[287]

When submitting an appeal by mail, customers should provide an explanation, and documentation whenever possible, regarding the decision being challenged and why he or she believes the determination is inaccurate.[288] For example, if a customer is appealing a termination notice, the customer should submit a copy of that notice along with the appeal. Customers submitting an appeal from within their online account are required to select the notice they are appealing from a drop-down menu, and may upload other relevant documentation to their account. If filing an appeal online, customers should also provide a short explanation regarding the reason for their appeal in the box provided.

3) Notice of Receipt of Appeals Request

EOHHS, upon receipt of an appeal request, will send timely acknowledgement to the appellant of receipt of the request. The acknowledgement will include information regarding potential eligibility pending appeal, and must clarify that any APTCs applied to the account pending the appeal are subject to reconciliation.[289]

Because an appeal submitted by an employee covered through SHOP may impact the employer, the employer will be notified if an employee submits a valid appeal.[290]

4) Appeals Account Management

Customers can manage their appeal request in the same channels that they submit their appeals request: in-person, by mail, by telephone, by fax, or online. From within their online account, customers may designate an authorized representative, request the appeal to be expedited, choose to withdraw an appeal, and upload supportive documents. Customers may be provided an opportunity to examine documents and records used during the hearing, at a reasonable time before the hearing, and during the hearing.[291]

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[286] 210-RICR-10-05-2.2.1(A)(9).
[287]210-RICR-10-05-2.2.1(A)(2).
[288] Appeals Operations Manual, Rhode Island Unified Health Infrastructure Project, Draft v 1.0 (July 26, 2013) at 14.
[289] 45 CFR 155.520(d)(1).
[290] 45 CFR § 155.740(g)(1).
[291] 210-RICR-10-05-2.3.1

In the SHOP Exchange, appellants will receive "desk reviews", although hearing requests will be considered.[292] A "desk review" means the hearing officer reviews, and bases his/her decision on, written submissions and evidence from the appellant and any appropriate state agency representative(s). To request a desk review, the appellant must notify the EOHHS appeals office or the HealthSource RI Contact Center in advance and:

- If the hearing has already been scheduled, this advanced notice shall be given no less than five business days before the scheduled hearing. In such cases, the written submissions shall be due on the day the hearing would have occurred.
- If the hearing has not yet been scheduled, the appellant may request the desk review at any time, and the written submissions shall be due within ten (10) days of such request or at such other deadline to be agreed between the appellant and the EOHHS Central Appeals Office.

Upon requesting a desk review, the appellant forfeits his or her opportunity for an in-person hearing.

5) Assignment of Authorized Representative

Appellants have the right to designate an Authorized Representative to represent them at any stage of an appeal.[293] Designation of an authorized representative may be made in the following ways:

- By mailing in a signed document to a DHS office or the HealthSource RI Customer Support Center;
- By adding a representative via telephone through the Contact Center;
- By accessing their online account; or
- By going in-person to the HealthSource RI Contact Center or DHS Office. If the designation is in person, a written designation will also be required.

For SHOP appeals, employers and employees may select an Authorized Representative specifically for an appeal as part of the appeal request. If an employer already has an agent or broker as an Authorized Representative and does not actively select an Authorized Representative, the agent or broker remains the Authorized Representative for the appeal. Employees must actively select an Authorized Representative for an appeal. All correspondence generated through the EOHHS Appeals Office for an appellant who has designated an Authorized Representative must be sent to that representative, in addition to the appellant.[294]

6) Informal Resolution

The Informal Resolution (IR) process is a fundamental component of the appeals process. HealthSource RI will make a concerted effort to resolve customer disputes prior to the formal hearing date. DHS may conduct informal resolution for MAGI Medicaid-related appeals. Informal resolution involves reaching out to the customer at the telephone number and email address listed in the customer's online account and asking for additional information that will help HealthSource RI resolve the issue. Every attempt will be made to resolve the appealable issue(s) prior to hearing, however if the appellant remains dissatisfied with the outcome of the

[292] 210-RICR-10-05-2.4.5
[293] 42 CFR 435.923(a) and (b); 45 CFR 155.505(e).
[294]210-RICR-10-05-2.3.1(F)..

IR process, his or her right to a hearing is preserved.[295]

If the attempt was successful, the customer will be provided an opportunity to withdraw his or her formal hearing request. If the attempt was unsuccessful, the customer's right to a formal hearing stands and the scheduled hearing date remains unchanged.[296] HealthSource RI may continue its efforts to resolve the customer's issue informally, up until the date of the applicable agency's decision, if necessary. If the appeal advances to a hearing, the appellant will not be asked to provide duplicative information or documentation that he or she previously provided during the application or informal resolution process.

An informal resolution process for a SHOP appeal may end in either a formal appeal decision or the employer or employee may withdraw the appeal. Like the individual market appeals process, all withdrawals of appeals must be in writing.[297]

7) Withdrawal of Hearing Request

The appeal request must be dismissed if an appellant withdraws the request in writing or by phone.[298] When requesting the withdrawal the customer may:

- Upload a signed withdrawal request in customer's online account;
- Call HealthSource RI;
- Request a withdrawal in-person at a HealthSource RI Walk-In Center by completing a withdrawal request form; or
- Mail or fax a written withdrawal request form to a DHS Field Office or to HealthSource RI.[299]

8) Request for a Continuance (Reschedule)

An appellant must request to reschedule the hearing by contacting EOHHS Appeals Office at (401) 462-2132 prior to the hearing. No more than two requests for continuance will be granted unless the EOHHS Appeals Office exercises its discretion to allow for more than three continuances after a demonstration of good cause.[300]

9) Abandonment of Hearing Request

A hearing will be dismissed upon determination that it has been abandoned.[301] Abandonment occur when, without good cause, an individual or his or her Authorized Representative fails to appear at a hearing and has not notified the EOHHS Appeals Office prior to the hearing. The customer may call the EOHHS Appeals Office to reschedule the hearing up until the time of the hearing.

The customer will be notified in writing that the hearing request is considered abandoned and that he or she

[295] 210-RICR-10-05-2.2.4
[296] Appeals Operations Manual, Rhode Island Unified Health Infrastructure Project, Draft v 1.0 (July 26, 2013) at 24.
[297] 45 CFR § 155.740(i)(1)(i).
[298] 45 CFR 155.530; 42 CFR 431.223; 210-RICR-10-05-2.
[299]
[300] 210-RICR-10-05-2.3.1(E).
[301] 210-RICR-10-05-2.3.1(E).

may contact the EOHHS within ten days if he or she wishes to reschedule the hearing and can demonstrate good cause for failing to attend the hearing.[302]

Good cause for failure to attend a hearing shall include, but is not limited to:

- Sudden and unexpected event (such as loss or breakdown of transportation, illness or injury, or other events beyond the individual's control) which prevented the individual's attendance;
- Injury or illness that reasonably prohibited the individual from attending;
- Death in the family.[303]

10) Notice of Hearing

Appellants must be provided with written notice once a hearing has been scheduled. The EOHHS Appeals Office will provide written notice to the appellant of the date, time, and location or format of the hearing once it is scheduled and no later than 10 business days prior to the hearing date and no later than 15 days if it is an appeal related to eligibility for APTCs or CSRs.[304]

For appeals related to the SHOP Exchange, employers and employees both retain the option to elect a "desk review" in lieu of a hearing.[305] A desk review means the written submissions and evidence shall be reviewed and a decision will be issued by an EOHHS hearing officer.

SHOP appellants may request a desk review by notifying the EOHHS appeals office or HealthSource RI. If the hearing has been scheduled, the appellant may schedule a desk review any time at least 10 or more days prior to the date the hearing is scheduled. An appellant may request a desk review at any time if a hearing has not yet been scheduled. Evidence and written submissions must be provided within 10 days of the request for desk review or at an agreed upon date between the appellant and the EOHHS Central Appeals Office.[306]

11) Aid Pending

A customer who files an Eligibility Appeal may be eligible to continue their previous level of eligibility pending appeal.[307] Aid pending is available to customers who appeal an eligibility redetermination that occurred within 30 days of the date the appeal is filed. The customer must request to receive Aid Pending by telephone to HealthSource RI within 30 days of the eligibility redetermination occurring. Aid Pending is limited to customers appealing an eligibility redetermination.[308] New applicants who have been denied eligibility may not receive Aid Pending.[309]

Once a customer is determined eligible to receive Aid Pending, HealthSource RI will continue the customer's eligibility for enrollment in a QHP, APTCs and CSRs, as applicable, in accordance with the level of eligibility in

[302] 210-RICR-10-05-2.3.1(E).
[303] 210-RICR-10-05-2.3.1(E).
[304] 45 CFR 155.535(b)
[305] 210-RICR-10-05-2.3.5.
[306] Id.
[307] 45 CFR §155.525
[308] 45 CFR §155.330(e)(1)(ii); 45 CFR §155.335(h)(1)(ii); 78 Fed. Reg. 169
[309] 78 Fed. Reg. 169

effect immediately before the redetermination being appealed. A customer must continue to pay premiums or HSRI may terminate coverage as provided in 45 CFR 155.430(b)(2)(ii). APTCs paid while the appeal is pending are subject to IRS reconciliation at the end of the tax year. If the appeal results in a determination that is unfavorable to the customer (e.g., reduces the amount of APTCs for which he or she is eligible) the individual would be liable to repay APTCs for which the IRS determines he or she is not eligible.

12) Supportive Documents

Customers have the opportunity to submit supportive documents in person, online, by mail, or by fax via HealthSource RI. Documents submitted online will be automatically uploaded to the customer's online account. Documents submitted in-person, by mail, or by fax will be digitally scanned and uploaded into the customer's account and will be included in the Evidence Packet for all appeals other than SHOP. Documents submitted for a SHOP appeal will be incorporated into the evidence presented.[310]

13) Evidence Packet

Individuals must be given the right to examine their case file/appeal record, including all documents and records to be used during the hearing, at a reasonable time before the date of the hearing and during the hearing. Customers must be given the right to question or refute any evidence being used in the appeal.[311] Requests for copies of the evidence packet may be submitted by telephone or in-person.

In order for Federal Tax Information (FTI) to be included in the evidence packet and reviewed during the hearing, all adults in the household must sign a release. The Hearing Officer and support staff must also sign a user acceptance form in order to view FTI.

In the SHOP Exchange, customers are permitted to submit evidence.[312] The Exchange will consider requests for an evidence packet for SHOP Exchange from appellants whose appeal will be adjudicated with a hearing.

14) Agency Response

The responsible agency for the appeal may prepare an agency response that will be presented at the appeal hearing and will be included in the evidence packet. The agency response summarizes the agency's findings, supports the original agency action and includes the regulation or policy used for the decision.

15) Appeal Hearing Modality and Adjudicators

Appeals hearings must be heard orally; conducted at a reasonable time, date and place; and adjudicated by an impartial hearing officer.[313]

An Interpreter will be made available for individuals needing interpretive services.
During the hearing, the customer may present additional documentation and present his or her case to the

[310] Appeals Operations Manual, Rhode Island Unified Health Infrastructure Project, Draft v 1.0 (July 26, 2013) at 34.
[311] 42 CFR 431.242 and NPRM; 45 CFR 155.535(d).
[312] 45 CFR § 155.740(j).
[313] 42 CFR 431.205(d); 42 CFR 431.240; Proposed 45 CFR 155.505(d); Proposed 45 FR 155.535(c); Preamble 4648.

Hearing Officer, who will be hearing the case *de novo* (with no prior knowledge of the specific issue). The hearing must be recorded and witnesses will be sworn in by the appeals officer.[314] The following procedure shall be followed for every hearing:

- A statement by the appeals officer reviewing the hearing purpose; the reason for the hearing; the hearing procedures; the basis upon which the decision will be made; and the manner in which the individual will be informed of the decision;
- A statement by the agency representative setting for the policies under which the action was taken or denied;
- A statement by the claimant (or his or her Authorized Representative) outlining his or her understanding of the issue; and a full and open discussion of all facts and policies at issue by participants under the active leadership of the appeals officer.[315]

16) Expedited Appeals

A customer may request an expedited process when there is an immediate need for health services because a standard appeal could seriously jeopardize the customer's life or health or ability to attain, maintain or regain maximum function.[316] If the request for an expedited appeal is denied, the EOHSS Appeals Office must handle the appeal request under the standard timeframe and make "reasonable efforts" to inform the appellant through electronic or oral notification of the denial.[317] Expedited appeal requests will be reviewed on a case-by-case basis.[318]

Expedited appeals are not available for SHOP-related appeals.

17) Decisions

The appeal decisions must be written and based exclusively on relevant evidence provided during the course of the appeal, including during the hearing, and applicable law. Decisions must:

- State the decision, including a plain language description of its effect on an appellant's eligibility;
- Summarize the facts relevant to the appeal;
- Identify the legal basis for the decision, including the regulations that support it and any and all conclusions of law;
- State the effective date of the decision; and
- Explain the customer's right to pursue an appeal with HHS if he or she remains dissatisfied with the APTC/CSR eligibility determination.[319]

EOHHS will issue the written notice of the appeal decision to the customer within 90 days of the appeal

[314] 210-RICR-10-05-2.3.1(N).
[315] 210-RICR-10-05-2.3.1(N).
[316] 45 CFR 155.540(a); 42 CFR 431.244.
[317] 45 CFR 155.540(b); 42 CFR 431.244(f)(3)
[318] Appeals Operations Manual, Rhode Island Unified Health Infrastructure Project, Draft v 1.0 (July 26, 2013) at 12.
[319] 45 CFR S. 155.545(a), also 210-RICR-10-05-2.3.2.

request, as administratively feasible.[320] EOHSS must make the appeal record or decisions, as relevant, accessible to the customer at a convenient place and time, and must also provide public access to all appeal records or decisions subject to applicable federal and state privacy and confidentiality laws, which will require redactions of personal information where appropriate.[321] EOHHS will ensure that appeal records or decisions, as relevant, are made available to the appellant or the public upon request and in hard copy or electronically.[322]

In the SHOP Exchange, the appeal record must be accessible to employers for an employer appeal. The appeal record must be accessible to both employers and employees for employee appeals.[323] Confidential information will be redacted and SHOP appeals will not be publicly available.[324]

Decisions will be disseminated in writing to the following people and agencies, dependent upon the program eligibility of the customer:

- Appellant
- Authorized Representative, if assigned
- DHS Field Worker
- DHS Casework Supervisor
- DHS Regional Manager
- EOHHS Policy Office
- Associate Director, Division of Medical Services (only in cases when the Medicaid decision was in favor of the appellant)
- HealthSource RI Legal Counsel and Appeals Team[325]
- Employer in the case of an employee appeal in the SHOP Exchange.[326]

Any decision in favor of the individual shall apply:[327]

- Prospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with §155.330(f)(2), (3), (4), or (5); or
- Retroactively, to the date of the incorrect eligibility determination was made, at the option of the appellant.

Additionally, if a decision is entered in favor of an individual, HealthSource RI will redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision, in accordance with the standards specified in§ 155.305.

D. Appendix

1) Sample Appeal Form

[320] 45 CFR 155.545(b)(1); 210-RICR-10-05-2.3.2(H).
[321] 45 CFR 155.550
[322] Preamble 4666
[323] 45 CFR §155.740(o) referencing 45 CFR §155.550
[324] Id.
[325] Appeals Operations Manual, Rhode Island Unified Health Infrastructure Project, Draft v 1.0 (July 26, 2013) at 10-11.
[326] 45 CFR § 155.740(m).
[327] 45 CFR §155.545(c)

APPEAL FORM

Appeal Request Process

You may request an appeal by doing one of the following below. If you submit this form, the state will complete a review of your case to try to resolve the issue.

- **Online.** Log into your account at www.healthyrhode.ri.gov and click on "file an appeal".
- **By phone.** You can file an appeal regarding Medicaid and Private Health Coverage through HealthSource RI by calling HealthSource RI at 1-855-840-HSRI (4774). For questions about filing an appeal for human services programs such as SNAP, RIW, Child Care, GPA, or SSP call the Department of Human Services at 1-855-MY-RI-DHS (1-855-697-4347).
- **In person.** For in-person assistance visit **www.dhs.ri.gov** to view office locations.
- **By mail**. Complete this form and mail it to ATTN: Appeals STATE OF RHODE ISLAND, P.O. BOX 8709, CRANSTON, RI 02920-8787.

Name (required): _____

Date of Birth (required): _____

Account Number: _____

Address (required): _____

Phone number: _____

Email: _____

Do you need help speaking, reading or writing English? ☐ Yes ☐ No:

If yes, what is your primary language? _____

Preferred method of contact (circle one): email / paper mail

You must check off the reason(s) for your appeal:

Health Coverage:	Human Services:		
_____ Medicaid	_____ SNAP	_____ GPA	
_____ Private Plan - HealthSource RI	_____ RIW	_____ CHILD CARE	
_____ Both/Unsure	_____ SSP		
_____ Other (Please explain)	_____		

Please explain the reason for your appeal:

Do you need important health services or SNAP benefits immediately? If so, would you like an expedited appeal? ☐ Yes ☐ No:

If yes, Please explain:

IF THE HEARING DECISION IS NOT IN MY FAVOR, I UNDERSTAND THAT I MUST REPAY ANY ASSISTANCE AND/OR SNAP BENEFITS FOR WHICH I AM DETERMINED INELIGIBLE

☐ Check this box if someone is going to help you with the appeal or represent you during the appeals process. This can be an attorney, friend, or family member. Provide this person's contact information:

Name: _____

Phone: _____

Address: _____

Email: _____

Would you like your coverage and benefits to continue unchanged while you wait for a hearing decision? ☐ Yes ☐ No:

Signature _____ Date _____

(Recipient)

TO BE COMPLETED BY THE AGENCY ONLY:

APPEAL IS ABOUT: _____ RIW _____ MEDICAID _____ GPA

_____ SNAP _____ PRIVATE HEALTH PLAN _____ CHILD CARE

_____ OTHER

Indicate Specific Policy Manual Reference: Section(s) _____

Agency response to appeal/explanation: _____

Agency Representative (Signature) _____ Supervisor(Signature) _____

(Print Name) _____ (Print Name) _____

Local Office _____

For More information visit www.healthyrhode.ri.gov
Para más información visite www.healthyrhode.ri.gov
Para mais informações visite www.healthyrhode.ri.gov

Chapter 10: Shared Responsibility Payment & Exemptions

E. Overview of Shared Responsibility Payment & Exemptions

The Patient Protection & Affordable Care Act (ACA) requires that individuals have "minimum essential coverage" (MEC) each month of a calendar year or make a shared responsibility payment (sometimes referred to as a "fee") when they file their federal income tax return after the end of the year.[328] Taxpayers must pay the shared responsibility payment for themselves and for any tax dependents who did not have MEC.[329] The shared responsibility payment is based on the number of months for which an individual does not have MEC (with some exceptions described below). If the individual has MEC for a single day in a month, the individual is considered to have MEC for that month.[330]

The shared responsibility payment is shown in the following table.[331] Individuals who are required to make a shared responsibility payment must pay the greater of a set percentage of income above the tax-filing threshold[332] or a flat dollar amount as shown in the table below. There is a cap on the amount of the shared responsibility payment for families regardless of family size. *The total shared responsibility payment for the taxable year may not exceed the national average of the annual premiums of a Bronze plan offered through the federal marketplace.*

Table 1. Shared Responsibility Payment

	Payment is the greater of:		
Year	**Income Above Tax-Filing Threshold (%)**	**Flat Dollar Amount**	
		Adult	Child
2016 and beyond	2.5%	$695	$347.50
		(up to $2,085 per family)	

After 2016, the $695 shared responsibility payment may be adjusted for cost-of-living changes.[333]

If an individual lacks MEC for the entire year, he or she will be required to pay the full shared responsibility payment. If a customer goes without MEC for only a subset of months, the size of the shared responsibility payment is pro-rated based on how many months an individual lacked MEC.[334] For example, an individual who lacks MEC for 6 months of the year would be required to pay 50% (derived from 6 /12= .50) of the shared responsibility payment identified in the Table 1 above.

Individuals and families are able to apply for an exemption from this requirement under the Affordable Care Act ("ACA"). There are several categories of of exemptions.[335] In general, these exemptions are designed to ensure

[328] ACA Section 1501; 26 CFR 1.5000A-1(a)
[329] ACA Section 1501; 26 CFR 1.5000A-1(c)
[330] 26 CFR 1.5000A-1(b)
[331] 26 CFR 1.5000A-4(b)
[332] IRS sets the tax filing threshold annually. Individuals whose gross income exceeds the tax filing threshold are required to file a tax return. There are different thresholds for each of the following tax filing status type single, head of household, married filing jointly and surviving spouses, married filing separately. These thresholds will need to be used to calculate an individual's shared responsibility payment.
[333] 26 CFR 1.5000A-4(b)(iv)
[334] 26 U.S. Code § 5000A(e)(4)(B)(iii)
[335] ACA Section 1311; 26 CFR 1.5000A-3

that individuals facing financial hardship or who have religious or other reasons not to enroll in coverage do not face a financial penalty. There also is an exemption for customers who have short gaps in coverage during the calendar year.[336] Eligibility for these exemptions and the application process to apply for an exemption are described in detail below.

F. Minimum Essential Coverage (MEC)

1) Overview

Individuals who did not have MEC for three or more continuous months in the previous year are required to make a shared responsibility payment when they file their federal income taxes after the end of the year.[337] In other words, individuals may go *up to* three months without MEC without incurring a penalty, but once they have gone three or more months without MEC, the "short gap in coverage" exemption would no longer apply. The following types of private and government-sponsored health coverage qualify as MEC:[338]

Private Coverage
Employer-sponsored plan, including:[339] • Group health insurance plan offered by, or on behalf of, an employer to employees.[340] • Self-insured group health plans under which coverage is offered by, or on behalf of, an employer to the employee, regardless of whether the plan could be offered in the large or small group market in a state;[341] • COBRA coverage;[342] • Retiree coverage;[343] and • Plans offered to an employee by a third party, such as a professional employer organization or leasing company, on behalf of an employer.[344]
• Individual market plan, including a plan purchased through HealthSource RI.[345]
• Grandfathered health plan.[346] A grandfathered plan is an individual or group health insurance plan that was in existence prior to March 23, 2010, has continuously provided coverage since then, and that has not undergone substantial change.
• Self-funded student health coverage[347] (for plan years that begin prior to or on December 31, 2014; after this date, plans must secure recognition from HHS to be deemed MEC)
Government-Sponsored Coverage

[336] 26 U.S. Code § 5000A(e)(4)(A)
[337] 26 U.S. Code § 5000A(b)(1)
[338] ACA Section 1501; 45 CFR 156.602. Note that this definition of MEC is for the purpose of the shared responsibility payment; this is not the MEC definition used to determine eligibility for advance premium tax credits and cost sharing reductions.
[339] ACA Section 1501; 26 CFR 1.5000A-2(c)
[340] 26 CFR 1.5000A-2(c)
[341] 26 CFR 1.5000A-2(c)(ii).
[342] See IRS Questions and Answers on the Shared Responsibility Payment, available at: http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision. Accessed November 11, 2013.
[343] 78 Fed. Reg. 53650
[344] 26 CFR 1.5000A-2(c)
[345] ACA Section 1501; 26 CFR 1.5000A-2(d)
[346] ACA Section 1501; 26 CFR 1.5000A-2(e)
[347] 26 CFR 156.602(a)

Medicare Part A Coverage[348] and Medicare Advantage[349]	Medicaid[350] (there are limited exceptions described in detail below)
Certain types of veterans' health coverage[351] and TRICARE military coverage[352]	Children's Health Insurance Program, also known as RIte Care[353]
Peace Corps volunteer plans[354]	Non-appropriated Fund Health Benefits Program of the Department of Defense[355]
Refugee Medical Assistance coverage[356] that provides up to eight months of coverage for refugees.	State high risk pool coverage[357] (for plan years that begin prior to or on December 31, 2014; after this date, plans must secure recognition from HHS to be deemed MEC)

a) Types of Limited Medicaid Coverage That do not Count as MEC

Individuals who are enrolled in Medicaid and receive full benefits are considered to have MEC. However, some individuals who receive limited benefits under Medicaid are not considered to have MEC for purposes of the shared responsibility payment. The following types of Medicaid coverage are not considered to be MEC:

- Coverage of pregnancy-related services provided to pregnant women under selected Medicaid eligibility categories.[358]
- Optional coverage of family planning services.
- Coverage of emergency medical conditions for individuals who are ineligible for Medicaid due to their immigration status.
- Optional coverage of tuberculosis-related services.

G. Exemptions from the Shared Responsibility Payment

1) Overview

Some individuals may be eligible for an exemption from the shared responsibility payment. In general, these exemptions are designed to ensure that individuals facing financial hardship or who have religious or other reasons not to enroll in coverage do not face a financial penalty.

Depending upon the type of exemption being sought, individuals have two ways to seek an exemption – they may apply for an exemption through the Centers for Medicare and Medicaid Services ("CMS") or claim the

[348] ACA Section 1501; 26 CFR 1.5000A-2(b)(i)
[349] 26 CFR 156.602(c)
[350] ACA Section 1501; 26 CFR 1.5000A-2(b)(ii),
[351] ACA Section 1501; 26 CFR 1.5000A-2(b)(v).
[352] ACA Section 1501; 26 CFR 1.5000A-2(b)(iv). For additional information on veteran's health care programs see 38 USC 17.
[353] ACA Section 1501; 26 CFR 1.5000A-2(iii)
[354] ACA Section 1501; 26 CFR 1.5000A-2(b)(vi). For additional information on Peace Corps volunteer plans see 22 USC 2504(e).
[355] 26 CFR 1.5000A-2(b)(vii). This program is also an eligible employer-sponsored plan (78 Fed. Reg. 53651).
[356] 26 CFR 156.602(b)
[357] 26 CFR 156.602(d)
[358] Includes individuals enrolled in the Mandatory Poverty-level-related Pregnant Women and Infants group (1902(a)(10)(A)(i)(IV)) and the Optional Poverty level-related Individuals group (1902(a)(10)(A)(ii)(IX)).

exemption when they file their federal income taxes.[359] Notices of the exemption eligibility result issued by CMS will contain a certificate number.

Customers should keep this number to use when they file their federal taxes. Federal rules determine which of the routes are available for each exemption. In some instances, tax filers have a choice – they may apply for a certificate of exemption through CMS or claim the exemption when they file federal income taxes.

For more information about types of available exemptions or the process for filing an exemption with CMS or through your tax filing, visit:
https://www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee/.

[359] 45 CFR 155.625

Chapter 11: HealthSource RI Shop Eligibility

A. Overview of HealthSource RI SHOP

The State of Rhode Island operates a Small Business Health Options Program (SHOP) Exchange to provide employers with 50 or fewer employees access to qualified health plans. Employer eligibility to participate in the SHOP Exchange is determined immediately when an employer establishes an account. Employee eligibility is established by the employer's placement of the employee on the employer census.

Employers have two options for providing their employees access to qualified health plans: the Single Plan option or the Full Employee Choice option. Employers selecting the Single Plan option will make one health plan available to all eligible employees. Employers electing Full Employee Choice will make a standard contribution to the employer-sponsored coverage and the employees may use the contribution to purchase any health plan in the SHOP Exchange they choose.

Unlike individual coverage, employers may enroll in the SHOP Exchange to provide coverage to employees at any time during the year. Eligible employees will have a standard election period set by the employer[360] once the employer enrolls in SHOP or when the employee joins the employer.

Brokers have historically played a critical role in the enrollment and maintenance of small group health plans, and this relationship continues in the SHOP Exchange. If authorized by an employer, brokers can be assigned to the employer's account and make decisions regarding employers' and employees' coverage options.

This Chapter contains additional details on employer and employee eligibility for SHOP, conditions regarding enrollment periods, ancillary products, broker representation, payment policies, and disenrollments from SHOP. The Appendix contains information on the Small Business Tax Credit available to certain SHOP employers to help them pay for health insurance premiums, as well as information on COBRA and "mini-COBRA" coverage for employees.

B. SHOP Employer Eligibility & Enrollment Procedures

Small employers located in Rhode Island can participate in the SHOP Exchange if they offer coverage to all full time employees and provide an acceptable contribution toward employee coverage costs. This section details the specific eligibility requirements for small employers wanting to participate in the SHOP Exchange. This section also distinguishes between information that is needed to determine SHOP eligibility versus information that is needed to establish an employer SHOP account in order for the employer to invite employees to enroll in coverage.

In order to view plans or get quotes before enrolling, employers, brokers and other representatives can go to www.HealthSourceRI.com and access a side-by side rate sheet, as well as use a plan rate calculator that displays a list of plans and rate information. Brokers are also offered a quoting tool. To actually offer employees health plans available through the SHOP Exchange, employers must create an account. Thus, at this time, employer eligibility is integrated with the account creation process.

[360] 45 CFR 155.725(c)(2)

1) SHOP Employer Eligibility Requirements

An eligible employer must meet three requirements: a) Must be a small employer, b) Must offer SHOP Exchange coverage to all full-time employees; and c) Must have a principal business address or a primary worksite with eligible employees in the SHOP Exchange service area (the State of Rhode Island).[361]

a) Employer must be a small employer

To qualify, employers must have at least one enrolled employee who is not the owner or the spouse of the owner.[362] An employer is any person with one or more employees acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan, and includes a group or association of employers acting for an employer in such capacity.[363] Starting in 2016, a small employer is defined as an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.[364]

An employee is defined as any individual employed by an employer.[365] The number of employees is determined according to Federal employee counting rules set forth in 26 U.S.C. 4980(H)(2) (see below).[366] Employers can use the Full-time Equivalent (FTE) Employee Calculator, available at https://www.healthcare.gov/shop-calculators-fte/, to count the total number of employees they have and see if they qualify for SHOP.

26 U.S. Code § 4980H – Shared Responsibility for Employers Regarding Health Coverage

(B) Exemption for certain employers
(i) In general an employer shall not be considered to employ more than 50 full-time employees if—
(I) the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and
(II) the employees in excess of 50 employed during such 120-day period were seasonal workers.

(ii) Definition of seasonal workers

[361] 45 CFR §155.710

[362] 45 CFR 155.710; 80 FR 10869

[363] 45 CFR 155.20 (*An employer* has the meaning given to the term in section 2791 of the PHS Act , except that such term includes employers with one or more employees); PHS Act, 42 U.S.C. §300gg-91(d)(6) (term "employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002 (5)}; 29 U.S.C. §1002(5)

[364] 45 CFR 155.20

[365] 45 CFR 155.20; PHS Act, 42 U.S.C. §300gg-91(d)(5); 29 U.S.C. §1002(6)

[366] 45 CFR 155.20; 26 U.S.C. 4980H(2)

The term "seasonal worker" means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

(C) Rules for determining employer size for purposes of this paragraph—

(i) Application of aggregation rule for employers

All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(ii) Employers not in existence in preceding year

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(iii) Predecessors

Any reference in this subsection to an employer shall include a reference to any predecessor of such employer…

(D) Full-time equivalents treated as full-time employees

Solely for purposes of determining whether an employer is an applicable large employer under this paragraph, an employer shall, in addition to the number of full-time employees for any month otherwise determined, include for such month a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

(E) Exemption for health coverage under TRICARE or the Veterans Administration

Solely for purposes of determining whether an employer is an applicable large employer under this paragraph for any month, an individual shall not be taken into account as an employee for such month if such individual has medical coverage for such month under—

(i) chapter 55 of title 10, United States Code, including coverage under the TRICARE program, or

(ii) under a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary.

Example: Rhode Island Manufacturing had no more than 48 employees working 30 or more hours for all of 2015. It increased its full time staff to 53 employees in January 2016. It applies for SHOP Exchange coverage on February 2, 2016 for coverage on March 1, 2016 and includes its current employee count of 53. Rhode Island Manufacturing is eligible for the SHOP Exchange because its employee count was less than 50 in the previous calendar year and it employs at least one employee on the first day of the plan year.

Affiliated companies must meet employee counting requirements. For purposes of this section, 'affiliated companies' means affiliated service groups, employees of a controlled group of corporations, and

employees of partnerships or proprietorships which are under common control.[367] Companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation, shall be considered one employer.[368]

Example: Mimi and Roger own 6 Clam Shacks across Rhode Island and southern Massachusetts with a total of 112 employees in the preceding calendar year. No single Clam Shack has more than 50 employees. Each Clam Shack applies for insurance through the Rhode Island SHOP Exchange separately. The Clam Shack is not eligible because although it has multiple separate locations, it files one tax return.

Any eligible employer that has been continuously enrolled in the SHOP Exchange may maintain enrollment in the SHOP Exchange regardless of the number of employees.[369] Employers that enter as eligible employers in the SHOP Exchange are "grandfathered" in to SHOP eligibility until they dis-enroll from the SHOP Exchange or fail to meet eligibility criteria unrelated to the employee count.

- Rhode Island State Law requires the size of a small employer to be re-determined annually.[370] However, the SHOP Exchange may not determine an employer ineligible, even if the number of employees at the employer increases beyond 50, so long as the employer is continuously enrolled in the SHOP Exchange.[371]

b) The employer must offer SHOP coverage to all full-time employees

To participate in the SHOP, eligible small employers must offer coverage through the SHOP to all full-time employees. Employers are permitted to self-attest that all full-time employees are offered coverage through the SHOP.[372]

c) The employer's principal business address or an eligible employees' primary worksite must be located in the SHOP Exchange service area (the State of Rhode Island)

Small employers that have a principle business address in Rhode Island are eligible to participate in the SHOP Exchange.[373] Employers located in Rhode Island will be asked to attest that the location of their primary address is in Rhode Island. Eligibility is based on this attestation.

Small employers who purchase insurance for employees whose primary worksite is in Rhode Island will be required to attest that although the location of their primary business address is outside of Rhode Island, the worksite of the eligible employees is in Rhode Island.
For companies with operations in Rhode Island and another state, employers have two options:

1. The employer may choose a single health plan with a multi-state or national provider network and offer it in all business operation locations. Employers should create a SHOP Marketplace account in the state where the primary business site is located.

[367] 26 CFR § 414 b), 26 CFR § 414 (c), 26 CFR § 414 (m), & 26 CFR § 414 (o)
[368] RIGL S. 27-50-3(kk) and 26 CFR § 414 b), 26 CFR § 414 (c), 26 CFR § 414 (m), & 26 CFR § 414 (o)
[369] 45 CFR 155.710(d)
[370] RIGL S. 27-50-3(kk)
[371] 45 CFR §155.710(d)
[372] The Exchange's eligibility process allows the SHOP to accept an attestation by an employer that it will offer coverage to all of its full-time employees,) (CMS-9989-F, March 27, 2012 p. 18400)
[373] 45 CFR §155.710(b)(3)(i)

2. The employer may create a SHOP Marketplace account in a state where the employees have a primary worksite. As long as the business meets all criteria to participate in SHOP, the employer can create a SHOP account. If the employer creates a SHOP Marketplace account in multiple states where the employer has primary worksites, the employer may select different offerings in each state.

2) SHOP Employer Enrollment Procedures

To enroll in SHOP, employers must comply with several operational requirements, including:

1. Create an account and provide Employer Census Information,
2. Choose a plan option;
3. Select a contribution amount; and
4. Select a dental plan.

While required to effectuate enrollment, these are procedural requirements, and are not conditions of employer eligibility.

a) Create An Account & Provide Employer Census Information

Employer Account Information

Employers must provide a broad set of account information including: Company Name, Company Legal Name, Number of FTEs, Address, City, Zip Code, First Name and Last Name, Primary Phone, Phone Type, and Email Address as part of the application process. In addition, employers must also provide an Employer Identification Number, Employee Census and Employer Tax and Wage reports, which are addressed in more detail below.

Employer Identification Number (EIN)

To enroll in the SHOP, businesses must provide a valid Employer Identification Number (EIN).[374] If an EIN is not provided, the Employer/Broker may not finalize the account application.

Employer Census

The employer census includes the complete list of employees and dependents to whom the employer is offering employer coverage. This is the single list that determines which employees at the employer will be eligible for coverage. The list should reflect employer choices and guidelines described in C.1 with respect to eligible employees. Individuals who work less than 17.5 hours per week are not eligible to be listed on the employer census. If employers offer dependent coverage, they must follow Rhode Island law when adding dependents to the Employer Census.

The State of Rhode Island General Laws TITLE 27 Insurance CHAPTER 27-50 Small Employer Health

Insurance Availability Act SECTION 27-50-3(j)
"Dependent" means a spouse, child under the age twenty-six (26) years, and an unmarried child of any age who is financially dependent upon, the parent and is medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months.[375]

The employer may either use the census template to upload the information or provide the information by phone, or manually. Employer account creation can continue for the employer without having complete account information (e.g. employee spouse social security number is missing).[376] The census can be edited until it is finalized. After it is finalized, it cannot be edited unless an employee has a special enrollment period.

Employer Tax and Wage Report

Employers provide a tax and wage report by uploading it to complete the employer's account creation. HealthSource RI SHOP can also upload these documents on behalf of the employer if they are submitted by fax, email, or on paper. Employers may not proceed to the employee open enrollment period without first providing Tax and Wage Reports. If a Tax and Wage Report is not available, employers may upload alternative documentation showing their eligible employees. A list of alternative documentation is available in Appendix D.

a) Employer Chooses Plan Option

Eligible employers who have successfully created SHOP Exchange accounts must provide the HealthSource RI SHOP with certain coverage determinations prior to HealthSource RI notifying employees of such coverage. Employers must choose either the Single Plan option or the Full Employee Choice option.

Single Plan Option: The employer selects one health plan and that is the only plan eligible employees and their dependents may enroll in.

Full Employee Choice Option: Eligible employees may enroll in any plan offered on the SHOP Exchange. Employers selecting Full Employee Choice must select a reference plan. The reference plan is the plan on which the employer's premium contribution is based. Employees selecting a plan other than the reference plan must pay or save the difference between the plans. While single choice and full choice are the models available to employers, HSRI will also work with employers to highlight a narrower list of plans by request.

b) Employer Selects a Contribution Amount

Employers must select a contribution amount of at least half of the cost of employee only coverage. In the Single Plan option, this is half of the cost of the selected plan. In the Full Employee Choice option, this is half of the cost of the reference plan.[377] This minimum amount is required to be contributed to each type of family tier.

[375] RIGL S. 27-50-3(j)

[376] The data elements on the employer census are: Last Name, First Name, Eligibility Type (e.g. Employee, Spouse or Dependent), Date of Birth, Address, Social Security Number, Associated Employee ID, Expected to Enroll, Coverage Level, Group, Selector; *see also* Phase 1 Functional Design – SHOP 4.51.2 Data Elements.

[377] The contribution is performed such that each employee would pay the same amount for coverage if enrolled in the reference plan.

The following are tier "levels" recognized by HealthSource RI:

- Employee-only
- Employee and Spouse
- Employee and Child(ren)
- Family
- Child(ren) only (Dental/COBRA only)

HealthSource RI permits employers to tailor employer contribution amounts based on employee position within the organization. Employers must adhere to Rhode Island anti-discrimination law in tailoring employer contribution levels.[378]

c) Employer Selects One Dental Plan

After selecting a health plan, the Employer selects exactly one dental plan. Selecting a dental plan is required, unless the employer attests to offering a separate dental plan that satisfies the pediatric dental portion of the Essential Health Benefits. Pricing for dental plans will be separate from medical plans on the Exchange. Employer contribution is optional for dental plans.[379] If an employer chooses not to contribute to dental coverage, employee rates will not be calculated in a composite manner; each employee will instead have rates specific to that employee and any dependents who are enrolling. While medical plans do not currently include embedded dental coverage, this may change in future years.

After the selection of the dental plan, employer plan selection is completed. The employee will then be notified of eligibility to participate in the SHOP Exchange.

d) SHOP Exchange Participation Requirements

Federal regulations permit the state Marketplaces to set participation rate parameters.[380] The participation rate refers to participation in the SHOP Exchange, and not participation in a specific QHP or QHPs from a specific issuer. To date, HealthSource RI has elected not to set any minimum participation standard.

C. SHOP Employee Eligibility Requirements and Enrollment Procedures

1) SHOP Employee Eligibility Requirements

SHOP employee eligibility is based on the employer census. An employee included on the employer census is an eligible employee, and is determined at the employer's discretion. An employee not included on the employee census is not an eligible employee. If for any reason, eligible employees are not included in the quarterly Tax & Wage report, additional supporting documentation may be requested by HealthSource RI. Employers may choose to include the dependent(s) of employees on the Employer Census. As explained above in B.2.a., dependents must meet the criteria of a "dependent" as defined under Rhode Island law. Employers may choose whether, as a general rule, to include employee dependents in the pool of eligible

[378] RIGL § 28-5-7(1)(ii)
[379] The contribution is performed such that each employee would pay the same amount for coverage if enrolled in the reference plan
[380] 45 CFR §155.705(b)(10)

candidates for coverage. If not covering employee dependents, employers cannot include them in the census.

When an employee's dependent reaches the age of 26, the dependent is no longer eligible for coverage through the employee's plan, and must seek an alternative source of coverage. When a dependent "ages out" of coverage, HealthSource RI will send the dependent a disenrollment notice and will dis-enroll the dependent as of their 26th birthday.

2) SHOP Employee Enrollment Procedures

Similar to employer eligibility, there are several operational requirements for employees to successfully effectuate enrollment in a health plan through the SHOP once they have been determined eligible. The employee will receive notification that his or her employer registered for the HealthSource RI SHOP and that the employee (and any dependents) is eligible for coverage. Employees must then:

1. Create an account;
2. Select a health plan (or choose not to enroll in a health plan); and
3. Select a dental plan (or choose not to enroll in a dental plan).

a) Create an Account

Employer Census Matching

Once an employee receives notification of eligibility from the HealthSource RI SHOP, the employee must establish an account. The employee must submit his or her First Name, Last Name, Date of Birth and Social Security Number. All furnished information must match the employer census exactly to successfully create an account. Therefore, ineligible employees not included on the census cannot be matched to an employer and cannot create an account.

Provide Employee Information

When the employee is present on the census, the employee proceeds to create an account. The employee must provide required information to create the account. Data elements include: Username, Password, First Name, Middle Name, Last Name, Suffix (e.g. Jr), Gender, Date of Birth, Social Security Number, Address Line 1, Address Line 2, Apt/Unit #, City, State, ZIP, Email Address, Three Security Questions and the User Acceptance Agreement. Once the information has been submitted and the account has been created, employees will be able to select a plan.

Specify Relationship to Household Members

Each employee is asked during account creation to confirm the relationship to each potential enrollee the employer has included on the census. The enrollee must be described as either "self," "spouse," or "dependent." If requested by the employer, the employee must be able to provide proof of the insurable

relationship.[381] An employer may request that HSRI remove an employee or dependent who is not eligible, as determined by the employer. Employee and dependent eligibility is determined by the employer in the event of a dispute.

Select Household Members Who Will Enroll

The employee must select which eligible members of the household are to be enrolled in a plan prior to selecting the plan. Based on the relationship defined above under *Specify Relationship to Household Members,* the family type will be determined and a correlating premium is applied. For example, if an employee enrolls herself and her spouse and no children, the plan type and pricing will be based on the family type "employee & spouse."

Composite Rating and Adjustments to Employer Contribution

The employer contribution is based on a composite rate calculated at the time that the employer application or renewal is submitted. To calculate the composite rate, first the total list bill premium for the group is calculated, based on the ages of all employees and dependents expected to enroll. The total is then broken into a composite rate, which represents an average cost for the reference plan for each family structure tier.

Adding or removing an employee or dependent any time after the application is submitted will result in a change to the total bill and to the initial employer contribution. The list bill rate for the employee or dependent will be added to or removed from the total bill. If the employee or dependent's rate, based on age, is different the original composite average rate, then the employer's average contribution will be adjusted to make up the difference. This can decrease or increase the employer's average contribution per employee. The employee contributions will stay constant throughout the rest of the plan year.

b) Select a Health Plan or Choose Not to Enroll in a Health Plan

The employer determines whether one or more plans are offered to employees.

Single Plan Option: If the employer has selected the Single Plan option, the employee may choose to enroll in the plan offered by the employer or choose not to enroll in a plan.

Full Employee Choice Option: If the employer has selected the full employer choice option, the employee is notified of the reference plan. The employee may enroll in any available plan offered through the HealthSource RI SHOP. The employee will be responsible for paying his or her contribution based upon the composite cost of the reference plan, plus or minus any difference between the "list-bill" cost of the reference plan and the "list-bill" cost of the plan selected by the employee. While single choice and full choice are the models available to employers, HSRI will work with employers to highlight a narrower list of plans by request.

c) Select a Dental Plan or Choose Not to Enroll in a Dental Plan

[381] RIGL S. 27-50-3(j); "Dependent" means a spouse, an unmarried child under the age of nineteen (19) years, an unmarried child who is a student under the age of twenty-five (25) years, and an unmarried child of any age who is financially dependent upon the parent and is medically determined to have a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months

Employees must then select a dental plan option. The employee can choose the plan made available by the employer or can choose not to enroll in coverage.

3) Employee Enrollment Period

a) Annual Open Enrollment

Each year the employer will have an open enrollment period, during which any eligible employee may make changes to his or her enrollment. Changes include: Enrolling in new coverage, changing plans, changing covered family members (enrolling or disenrolling dependents), enrolling in a dental plan, and other changes.

The SHOP must provide an initial open enrollment period, and an annual open enrollment period.[382]

b) Special Enrollment Periods for Employees and Dependents

The SHOP Exchange must provide employees and dependents with special enrollment periods when individuals meet the requirements listed below.[383] Employer-provided information can determine whether employees (or their dependents) qualify for a special enrollment period.
Newly qualified employees must receive an enrollment period starting on the first day of becoming eligible to enroll in the SHOP Exchange.[384] According to federal rules, the probationary period ("waiting period) for employee eligibility cannot exceed 90 days. It is the employer's responsibility to maintain records of employee hire dates and administer the probationary period.
Individuals are eligible for a special enrollment period if they meet one of the following criteria:

- A qualified individual becomes newly eligible for coverage (e.g., is newly hired or becomes eligible based on hours worked.)
- A qualified individual or dependent loses minimum essential coverage; failure to pay premiums is not considered a loss of minimum essential coverage.[385]
- A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption or foster care;
- A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
- Enrollee adequately demonstrates to HealthSource RI that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;
- An American Indian or Alaskan Native, as defined by Section 4 of the Indian Health Care

[382] 45 CFR § 155.725(e).
[383] see 45 CFR § 155.725(a)(3) ; also 45 CFR § 155.420(d)(1)-(2), 45 CFR § 155.420(d)(4)-(5), 45 CFR § 155.420(d)(7)-(10)
[384] 45 CFR § 155.725(g)
[385] 45 CFR § 155.420(e)

Improvement Act, may enroll in a QHP or change from one QHP to another one time per month;

- It has been determined by the Exchange the qualified individual/dependent was not enrolled in a QHP or was not enrolled in the QHP he or she selected (by a non-Exchange entity providing enrollment assistance/activities).
- A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide;
- Loses eligibility for Medicaid or CHIP (RIte Care), or becomes eligible for assistance (as related to coverage through SHOP) under Medicaid or CHIP (RIte Care) (60 day special enrollment period in these cases)
- QHP is decertified. If an employer has selected a QHP in Single Plan that has been decertified, employee coverage in that plan will end. The employer will be eligible to reselect a new plan for employees and employees will be eligible to elect to enroll or not to enroll in this coverage. If the employer has selected Full Employee Choice and one or more employees is enrolled in a QHP that is decertified causing coverage in coverage in that QHP to terminate, the terminated employees are eligible for a special enrollment period (SEP) to reselect a QHP.

c) Effective dates of coverage

The effective date of coverage is the first day of the month following the qualifying ("triggering") event, with exceptions for birth, adoption, and foster care, in which cases the effective date of coverage is the date of the qualifying event.

D. Employer & Employee Enrollment Periods

Employers may enroll in the HealthSource RI SHOP at any time during the year. For employees, the SHOP enrollment period differs from the Individual Exchange Marketplace; the latter has a set open enrollment period each year. The HealthSource RI SHOP has employer-specific annual open enrollment periods held throughout the year and in accordance with the employer's plan year.

Qualified employees are able to enroll in an eligible employer-sponsored plan during their employer's initial open enrollment period, during the employer's annual open enrollment period, and during special enrollment periods for which they may qualify.[386] New employees wishing to enroll in an eligible employer-sponsored plan are able to enroll once they are determined eligible, even if it is during the employer's plan year.

After an employer has elected to make coverage available to its employees through the SHOP, the SHOP will process the employee applications and facilitate the enrollment of qualified employees in QHPs.

1. Annual Open Enrollment Period

The SHOP features an open enrollment period for qualified employees prior to the completion of the applicable

[386] Please contact HealthSource RI for the most up-to-date policies for SHOP enrollment.

plan year.[387] The SHOP provides notification to each qualified employee of the annual open enrollment period in advance of such period.[388]

2. **Effective Coverage Dates for Annual Open Enrollment**

The SHOP effective dates of coverage for all qualified employees are consistent with the coverage effective dates established during initial open enrollment.

Example: A small sandwich shop has an effective date of coverage set for April 1. The annual enrollment period for the sandwich shop employees would begin on March 1 of the following year, and HealthSource RI would send the employees a notification about that enrollment period before March 1.

3. Newly Qualified Employees

SHOP employees who become eligible outside of the initial or annual open enrollment periods are entitled to an enrollment period lasting 30 days to purchase coverage in a QHP. At the discretion of the employer, the insurance carrier will ensure that the coverage is effective on the first of the month following the month when the employee became eligible; or the employer may ensure that coverage becomes effective on the first day of the month following the employee's enrollment.

Example: A new cashier at a grocery store becomes a qualified employee on May 15. His enrollment period will last from May 15 through June 15. If the cashier chooses to enroll on June 12, his effective date of coverage would be June 1, or July 1 depending on what the grocery store owner prefers.

4. Special Enrollment Periods

The SHOP grants flexibility to employers to determine the duration of special enrollment periods for qualified employees and dependents of qualified employees to enroll in or change plans.[389]
In addition to the list of qualifying events available to individuals listed in Section D of this Chapter, employees may be eligible for a special enrollment period as a result of any of the additional qualifying events:

- *Newly Eligible*: The qualified employee or dependent of a qualified employee becomes eligible for assistance with respect to coverage under a SHOP, under such Medicaid plan or a State child health plan (including any waiver or demonstration project conducted under or in relation to such a plan); or
- *Newly Ineligible:* The qualified employee or dependent of a qualified employee loses eligibility for coverage under a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act.

A dependent of a qualified employee is not eligible for a special election period if the employer does not extend the offer of coverage to dependents.

Example: A waitress was not enrolled in her restaurant's SHOP plan because she qualified for Medicaid. If she

[387] 45 CFR 155.725 (e)
[388] 45 CFR 155.725 (f)
[389] SHOP practices may differ from 45 CFR 155.725 (j)(3) in regards to special enrollment period durations.

earns more money and no longer qualifies for Medicaid starting July 1, she will qualify for a special enrollment period lasting until September 1, during which she may enroll in an employer-sponsored plan.

a. Regular Effective Coverage Dates for Special Enrollment Periods

At the employer's discretion, the Carrier and HealthSource RI will ensure that coverage for the qualified employee or the dependent of a qualified employee will be effective on the first day of the month following the month during which the triggering event occurred, or the employer can choose to have the coverage become effective on the first day of the month following the employee's enrollment.

Example: A florist gets married on July 18. If he chooses to enroll within the special enrollment period, his new spouse's effective date of coverage would be September 1, or depending on the election of the Employer, it could be retroactive to August 1.

a. Special Effective Coverage Dates for Special Enrollment Periods

In the case of a special enrollment-qualifying event such as a birth, adoption or placement for adoption, the SHOP must ensure that coverage is effective on the date of birth, adoption, or placement for adoption.

Example: Consider a baby girl is born, adopted, or placed for adoption on July 24. Her effective date of coverage would be July 24.

E. Eligibility and Enrollment Assistance

Brokers play an integral role in the procurement and maintenance of health insurance for small employers. The role of the broker does not change in the SHOP Exchange. For employers choosing to work with brokers to assist in enrollment and other processes, brokers will maintain the same traditional functions. In the Rhode Island SHOP Exchange, if authorized by an employer, a broker may select and manage the employer's health insurance offerings. In addition, a broker authorized by an employee may select and manage the employee's health insurance. Brokers may assist employers and employees without authorization for certain tasks such as browsing health plans, evaluating eligibility for the small business tax credit and other functions.

1) Designation of a Broker

Brokers may be designated by employers to act on behalf of the employer. Designation of a broker must be done electronically, in writing, or by phone.[390] Without authorization, which is considered legally binding by the HealthSource RI SHOP, a broker shall not be able to submit information or receive notices on behalf of an employer or the employees of that employer. The broker for the employer may act on behalf of an employee without formal authorization from the employee.

In order to be designated the authorized broker:

Broker must be certified. Broker certification requires that the broker pass a training course provided by an

[390] 78 FR 42313;,45 CFR §155.227(g)

Exchange Broker Liaison. The broker receives a broker certification number, which will be recognized by the HealthSource RI SHOP.

Broker must have an account. Broker may create a broker account any time after SHOP Exchange certification.

Privacy. Broker must comply with the privacy and security standards pursuant to 45 CFR §155.260, which limits how a broker may use any information gained as part of providing assistance and services to a qualified individual.

Duration. The designation of a broker by an employer is valid until:

- The employer designates an alternative broker. [391]
- The employer notifies the SHOP Exchange that the authorized representative is no longer authorized to act on the employer behalf.[392]
- The authorized representative notifies the SHOP Exchange that he or she will no longer act on behalf of the employer. [393]
- The authorized representative's SHOP Exchange account is closed.
- The authorized representative loses his or her certification.

2) Broker Functions On Behalf of an Employer

An employer's assigned broker may perform all SHOP Exchange functions on behalf of the employer. There is no limit to what functions a broker may perform and all information provided to the employer is also provided to the employer's assigned broker. An employer may request that the broker only perform a subset of SHOP Exchange functions. The following are typical examples of actions that brokers may perform on behalf of an employer:

- Create Account
- Plan Selection
- Manage Employer Census
- File Appeals

3) Broker and Employer Function On Behalf of an Employee

An employer's broker may perform all Exchange functions on behalf of the employees of that employer. There is no limit to what functions a broker may perform and all information provided to the employee is also provided to the employer's assigned broker. An employee may request of a broker that the broker only perform a subset of Exchange functions. Note that an employer may also perform these functions on behalf of employees. The following are typical examples of actions that brokers may perform on behalf of an employee:

- Create Account

[391] 45 CFR §155.227(d)(1)
[392] 45 CFR §155.227(d)(2)
[393] 45 CFR §155.227(d)(3)

- Plan Selection
- File Appeals

4) Broker - Related Assistance Not Requiring Authorization

Brokers do not require formal authorization from the SHOP Exchange to assist employers and employees in matters related to health insurance coverage, but not related to the SHOP Exchange. For example, without formal authorization, brokers may assist employees in providing information to the employer for the employer census. Brokers may assist employees by answering questions about plans on the HealthSource RI SHOP. Brokers may also assist employees with requesting special enrollment periods from employers and ensuring eligibility for COBRA. Brokers may quote an employer without first being authorized.

F. Termination from SHOP

This section addresses termination (disenrollment) from SHOP for both employers and employees. SHOP employers and employees can leave the SHOP at any time. This is often called a voluntary termination. Other terminations can be caused by a number of factors, including non-payment of premium or loss of eligibility. Federal regulation and Rhode Island policies set requirements around term and terminations. Federal regulations require issuers to maintain records of all terminations.[394]

1) Employer

a) Termination Due to Failure to Pay Premiums

Rhode Island requires that employers have a 30-day grace period before insurers are permitted to terminate the employer's coverage. Payment during that time period prevents termination. Termination is permitted if no payment is made at the end of the 30-day grace period. This termination is initiated by HealthSource RI.

If the grace period has passed and the employer has not paid premiums, coverage will be terminated effective the last day of the grace period.

Example: John's bait shop's premium payment for January was due on December 23, but John did not pay his bill by January 31. So coverage for the bait shop will be terminated effective January 31.

In event of adjustments to billing (e.g., added or removed a new employee in a given month but were already billed) for that month, an employer shall not be considered late in payment if the employer paid what they were initially billed for that month. Any adjustments will be reflected in the next billing statement, and the employer will not be considered late on payment.

After termination due to failure to pay premiums, information regarding any unpaid balance for a termed group will be transferred to the appropriate insurer(s). Insurers reserve the right to pursue collections for unpaid balances once transferred to them.

[394] 45 CFR § 156.270(h)

b) Termination Due to Loss of Eligibility

The Rhode Island SHOP Exchange only permits employers who either have a primary business address or have employees whose primary business location is in the service area to participate in the SHOP Exchange. If the SHOP Exchange learns that employers are no longer valid employers, or they no longer meet the location requirement, coverage will be terminated effective the end of the coverage month when this determination has been made. If an employer no longer qualifies as a group due to no "common law" employees enrolled, coverage will be terminated at the end of the plan year.

c) Voluntary Termination/Disenrollment

The HealthSource RI must permit an employer to disenroll from coverage.[395] Employers must contact the HealthSource RI SHOP to disenroll the group. The HealthSource RI SHOP must confirm that any outstanding payments are made before disenrollment. The employer's termination request must be in writing and received by HealthSource RI prior to the first day of the next month. The completion of the disenrollment occurs when the HealthSource RI SHOP provides the employer with a confirmation of disenrollment.

d) SHOP Group Reinstatements

As mentioned above, SHOP groups can be terminated for non-payment if they are more than 30 days behind on payment. If a group is terminated for non-payment, that group may request to be reinstated under certain conditions.

1. For groups requesting reinstatement within the same plan year: To be reinstated, the group must first pay all past due premiums and the premium for any uncovered months, including the current month. Once a negative balance covers all coverage months, including the current month, HealthSource RI will reactivate coverage for the employees of the group. The effective date will be the day after the termination date. A group may not be reinstated more than once during a plan year.
2. For groups requesting reinstatement for a month after their normal renewal month: Coverage *cannot* be reinstated back to termination date. Coverage can begin with a new plan year, on the first of the month after the request. To be reinstated, the group must first pay all past due premiums and the premium for the first month of their new span of coverage. Once a negative balance of at least one month's coverage exists on the account, HealthSource RI will create a new plan year for the group. The effective date will be no earlier than the first of the month after the request.

2) Employee

a) Employer Determines Employee is No Longer SHOP-Eligible

The HealthSource RI SHOP may initiate disenrollment from coverage if the enrollee is no longer eligible for coverage.[396] This includes the employer changing the employee's eligibility due to a change in employment status or another reason. If an employee is terminated from coverage for any reason, the employee must be

[395] 45 CFR § 155.430(b)(1)
[396] 45 CFR S. 155.430(b)(2)

given a notice of termination including the reason for termination and the termination effective date.[397] The employer must also notify the Exchange of the termination and the reason for termination. The employee may also have the right to enroll in coverage through COBRA or RI Extended Benefits, which are discussed in the appendix.

b) Employer Disenrolls from SHOP

The employer may either voluntarily dis-enroll from coverage or may be terminated for non-payment of premiums or other reasons. The result is the employee would no longer be eligible for coverage in the SHOP. In addition, as described in Appendix C, the employee would not be eligible for continuation coverage because the group health no longer exists.

c) Employee - Led Termination (Voluntary Termination)

HealthSource RI must permit an enrollee to disenroll in coverage.[398] Termination will be effective as of the date specified by the employee, but must be the last day of the month, or the last day of the prior month.

G. Effective Dates and Premium Payments

Effective dates of coverage are discussed in detail in Chapter 3. Premium payments and billing are discussed in detail in Chapter 12.

H. Ancillary Products

HealthSource RI for Employers partners to connect businesses with several low-cost ancillary benefits including vision, life, accident and medical bridge coverage.

For more information or to set up an in-person appointment, contact your broker or HealthSource RI for Employers.

I. Appendix A. Small Business Tax Credit

Overview: Section 45R of the Internal Revenue Code allows certain small businesses purchasing health insurance on behalf of employees through the Small Business Health Options Program (SHOP) Exchange to be eligible for tax credits for the first two years they offer coverage through the SHOP Exchange.[399] The credit has been available to employers meeting the same standards in years prior to the launch of the Exchange. Certain small employers are eligible to receive a small business tax credit under the ACA to reduce the effective cost of contributing to health insurance coverage.

1) General Eligibility for Small Business Tax Credit

[397] 45 CFR S. 156.270(b)
[398] 45 CFR § 155.430(b)(1)
[399] 26 CFR §45R

To be eligible for the credit, the small employers must:

- Employ no more than 25 full time equivalents (FTEs);[400]
- Have an average wage across all employees that does not exceed $50,000 (indexed annually after 2014); and
- Provide a contribution of at least 50 percent of the cost of premiums for all employees eligible for coverage.[401]

The IRS has clarified that, because the statute does not require the employees of the employer to be performing services in a trade or business, the tax credit is also available to household employers.[402]

2) Maximum Amount of Small Business Tax Credit

The amount of the tax credit varies by the type of organization and the year. The full credit is 50 percent of the employer portion of the premium for taxable employers. The full credit is 35 percent of the employer portion of the premium for tax-exempt employers. Tax-exempt employers receive the credit by reducing payroll tax liability by the amount of the credit.

	2014 and after[403]
Tax exempt business	35 percent
Taxable business	50 percent

3) Phase Out of Small Business Tax Credit

The tax credit is based on a sliding scale with the full amount available to employers with 10 or fewer FTEs and with average wages of $25,000 or less per year. The tax credit is reduced as the employer increases in size and/or if average wages are higher than $25,000. For a taxable employer in the SHOP Exchange, the tax credit is reduced from 50 percent at $25,000 in average wages to 0 percent at $52,000 in average wages for 2015 and 2016. These wage values increase annually. Simultaneously, the tax credit is reduced from a maximum of 50 percent at 10 FTEs to 0 percent at 25 FTEs.

Example: The cost of premiums for Melissa is $3,000 per employee. Because Melissa pays 100 percent of the premiums for her 8 employees, who earn an average of $24,000 a year, she will receive the full tax credit. This tax credit is 50 percent of the premium paid or $1,500 per employee enrolled. If Melissa contributed $2,000 to her employee premiums, she would receive $1,000 in tax credits for each employee enrolled.

[400] FTE calculation for the small business tax credit is different than FTE count for SHOP eligibility.
[401] 26 CFR §45R(d)
[402] See IRS Notice 2010-082, available at http://www.irs.gov/pub/irs-drop/n-10-82.pdf
[403] 26 CFR §45R(b)

4) Sample IRS Form 8941: Credit for Small Employer Health Insurance Premiums

Form **8941**

Department of the Treasury
Internal Revenue Service

Credit for Small Employer Health Insurance Premiums

► **Attach to your tax return.**

► **Information about Form 8941 and its separate instructions is at *www.irs.gov/form8941*.**

OMB No. 1545-2198

2014

Attachment Sequence No. **63**

Name(s) shown on return | **Identifying number**

A Did you pay premiums during your tax year for employee health insurance coverage you provided through a Small Business Health Options Program (SHOP) Marketplace (or do you qualify for an exception to this requirement)? (see instructions)

☐ **Yes.** Enter Marketplace Identifier (if any): _____

☐ **No.** Stop. Do not file Form 8941 (see instructions for an exception that may apply to a partnership, S corporation, cooperative, estate, or trust).

B Enter the employer identification number (EIN) used to report employment taxes for individuals included on line 1 below if different from the identifying number listed above

Caution. See the instructions and complete Worksheets 1 through 7 as needed.

1	Enter the number of individuals you employed during the tax year who are considered employees for purposes of this credit (total from Worksheet 1, column (a))	**1**	
2	Enter the number of full-time equivalent employees (FTEs) you had for the tax year (from Worksheet 2, line 3). If you entered 25 or more, skip lines 3 through 11 and enter -0- on line 12	**2**	
3	Average annual wages you paid for the tax year (from Worksheet 3, line 3). If you entered $51,000 or more, skip lines 4 through 11 and enter -0- on line 12	**3**	
4	Premiums you paid during the tax year for employees included on line 1 for health insurance coverage under a qualifying arrangement (total from Worksheet 4, column (b))	**4**	
5	Premiums you would have entered on line 4 if the total premium for each employee equaled the average premium for the small group market in which the employee enrolls in health insurance coverage (total from Worksheet 4, column (c))	**5**	
6	Enter the **smaller** of line 4 or line 5	**6**	
7	Multiply line 6 by the applicable percentage: • Tax-exempt small employers, multiply line 6 by 35% (.35) • All other small employers, multiply line 6 by 50% (.50)	**7**	
8	If line 2 is 10 or less, enter the amount from line 7. Otherwise, enter the amount from Worksheet 5, line 6	**8**	
9	If line 3 is $25,000 or less, enter the amount from line 8. Otherwise, enter the amount from Worksheet 6, line 7	**9**	
10	Enter the total amount of any state premium subsidies paid and any state tax credits available to you for premiums included on line 4 (see instructions)	**10**	
11	Subtract line 10 from line 4. If zero or less, enter -0-	**11**	
12	Enter the **smaller** of line 9 or line 11	**12**	
13	If line 12 is zero, skip lines 13 and 14 and go to line 15. Otherwise, enter the number of employees included on line 1 for whom you paid premiums during the tax year for health insurance coverage under a qualifying arrangement (total from Worksheet 4, column (a))	**13**	
14	Enter the number of FTEs you would have entered on line 2 if you only included employees included on line 13 (from Worksheet 7, line 3)	**14**	
15	Credit for small employer health insurance premiums from partnerships, S corporations, cooperatives, estates, and trusts (see instructions)	**15**	
16	Add lines 12 and 15. Cooperatives, estates, and trusts, go to line 17. Tax-exempt small employers, skip lines 17 and 18 and go to line 19. Partnerships and S corporations, stop here and report this amount on Schedule K. All others, stop here and report this amount on Form 3800, line 4h	**16**	
17	Amount allocated to patrons of the cooperative or beneficiaries of the estate or trust (see instructions)	**17**	
18	Cooperatives, estates, and trusts, subtract line 17 from line 16. Stop here and report this amount on Form 3800, line 4h	**18**	
19	Enter the amount you paid in 2014 for taxes considered payroll taxes for purposes of this credit (see instructions)	**19**	
20	Tax-exempt small employers, enter the **smaller** of line 16 or line 19 here and on Form 990-T, line 44f	**20**	

For Paperwork Reduction Act Notice, see separate instructions. Cat. No. 37757S Form **8941** (2014)

J. Appendix B. Notices

Below are lists of notices that are required under federal regulation to be sent to employer and/or employees.

1) Employer Notices

a) **Employer Notices:** Employer Notice of Incomplete Information: Once the small employer has received the SHOP application, the SHOP must notify the employer of any inconsistencies.[404]

b) **Employer SHOP Eligibility:** The SHOP must provide an employer seeking to purchase coverage through the SHOP with a notice of approval or denial.[405]

c) **Employer Notice of Annual Election Period:** The SHOP must provide notification to a qualified employer of the annual election period in advance of such period.[406]

2) Employee Notices

a) **Notice of Incomplete Information:** The SHOP must notify the individual of the inability to substantiate his or her employee status.[407]

b) **Employee SHOP Eligibility**: The SHOP must provide an employee seeking to enroll in a SHOP QHP with a notice of approval or denial.[408]

c) **Employee Notice of Enrollment:** The SHOP must ensure that a QHP issuer notifies a qualified employee of enrollment in a QHP with an effective date of coverage.[409]

d) **Employee Termination of Coverage Notice:** The SHOP must notify the employer if any employee terminates coverage from a QHP.[410]

e) **Employer Non-payment Notice: Employers will be notified if they fail to make a premium payment prior to the payment deadline.** Rhode Island state law dictates that a 30-day grace period be implemented in the small group market before the termination process is initiated.[411]

g) Employee Notice of Open Enrollment Period: The SHOP must provide notification to a qualified employee of the annual open enrollment period in advance of such period[412]

K. Appendix C. Continuation Coverage

The federal Consolidated Omnibus Reconciliation Act (COBRA) establishes continuation of coverage rights under group health plans. These rights are commonly referred to as "COBRA" rights. COBRA rights are generally limited to group health plans of employers with twenty or more employees,[413] but many states,

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[404] 45 CFR §155.715(d)(1)(ii)
[405] 45 CFR §155.715(e)
[406] 45 CFR §155.725(d)
[407] 45 CFR §155.715(d)(2)(ii))
[408] 45 CFR §155.715(f)
[409] 45 CFR §155.720(e)
[410] 45 CFR §155.720(h)
[411] 220-RICR-90-00-1.13(G)
[412] 45 CFR §155.725(f)
[413] ERISA § 601(b); PHS Act § 2201(b)(1). COBRA establishes continuation rights for private employer group health plans under ERISA. State and local government employers, which are not subject to the substantive requirements of ERISA, must nevertheless comply with

including Rhode Island, have established laws to extend similar rights to employees of employers with fewer than twenty employees.[414]

A. COBRA

The basic rule under COBRA is that a group health plan of an employer with 20 or more employees is required to provide each "qualified beneficiary" who would lose coverage because of a "qualifying event" an opportunity to elect "continuation coverage" within an "election period."[415] The following description of key provisions of COBRA does not address some special situations.

A "qualified beneficiary" is a spouse or dependent child covered under an employer's plan before a qualifying event occurs. The employee is also considered a qualified beneficiary in the case of an employee termination or reduction in hours.[416]

A "qualifying event" that triggers the COBRA continuation right is any of the following (when the event would otherwise cause a qualified beneficiary to loss coverage):

- Death of the covered employee.
- Termination (other than for gross misconduct), or reduction of hours, of the covered employee's employment.
- The divorce or legal separation of the covered employee.
- The covered employee becomes entitled to Medicare.
- A dependent child ceases to be a dependent under the terms of the plan.
- The employer files for bankruptcy. The loss of coverage in case of bankruptcy may occur any time within one year before or after the bankruptcy filing.[417]

The continuation coverage that is available to a qualified beneficiary must meet the following requirements:

- The benefits offered under the coverage must be identical to the benefits offered under the group health plan to beneficiaries who have not experienced a "qualifying event."
- In case of the covered employee's termination or reduction in hours, the coverage must extend for 18 months. If a second qualifying event, other than the employer's bankruptcy, occurs within the first 18 months, the continuation coverage may be extended for a total of 36 months.
- For other qualifying events, the coverage must continue for 36 months.
- Continuation coverage may terminate if the employer eliminates its group health plan entirely.
- Eligibility for COBRA may not be based on evidence of insurability.[418]

A qualified beneficiary may need to pay the full premium for COBRA coverage, plus up to a 2 percent administrative fee. That means the premium can be as high as 102% of the cost of coverage for similarly

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the COBRA continuation right under the terms of the PHS Act.

[414] RIGL S. 27-19.1-1.

[415] ERISA § 601(a); PHS Act § 2201(a).

[416] ERISA § 607(3); PHS Act § 2207(3).

[417] ERISA § 603; PHS Act § 2203.

[418] ERISA § 602; PHS Act § 2202.

situated individuals who have not had a qualifying event, including both the share paid by the employee and by the employer. COBRA coverage can be terminated if the employee fails to make a premium payment, but the qualified beneficiary has 45 days from the COBRA election to make the initial premium payment.[419]

The "election period" is the time with which the qualified beneficiary must notify the employer of the choice to exercise ERISA rights. The election period begins on the date coverage would terminate because of a qualifying event and lasts sixty days.[420] Coverage is effective on the date of the qualifying event, so coverage may be instituted retroactively.[421]

B. Rhode Island Extended Benefits

Rhode Island law provides continuation rights in addition to those provided under federal COBRA. State statutes such as these are sometimes referred to as "mini-COBRA" laws. Rhode Island's law has a different scope than COBRA: it only applies to insured group health plans, not self-insured group health plans, and covers all such plans, regardless of employer size, whereas COBRA covers all group health plans of employers with at least twenty employees. However, Rhode Island's Extended Benefits law does not apply to employers and employees in the construction industry that participate in a Taft-Hartley multi-employer welfare plan.[422]

Under RI Extended Benefits, an employee, spouse, or dependent may continue coverage for 18 months after coverage would be terminated due to layoff, death, or the workplace ceasing to exist. The continuation coverage cannot last longer than the period of time the employee was employed prior to the qualifying event, and terminates whenever the individual in continuation coverage becomes eligible for benefits under another group plan. The employee is responsible for paying the full premium rate. If the employer plan has fifty or fewer plan employees, the payments are made directly to the insurer but HealthSource RI will bill the individual who takes RI Extended Benefits and then forward the payment to carriers. The election to participate in continuation coverage under this provision must be made within thirty days of the layoff or death.[423]

[419] ERISA §§ 602(2)(C), (3), 604; PHS Act §§ 2202(2)(C), (3), 2204.
[420] ERISA § 605(a)(1); PHS Act § 2205(a)(1).
[421] ERISA § 602(2); PHS Act § 2202(2).
[422] RIGL S. 27-19.1-1(h).

[423] RIGL S.27-19.1-1(a)-(c).

K. Appendix D. Tax Documents for New Groups Without a Quarterly Tax and Wage Report

Tax Documents for New Groups without a Quarterly Tax and Wage Report

HSRI requires the most recent Form 941 (Quarterly Tax and Wage Report). *The documents below may be used when the group isn't required by law to file or hasn't been in business long enough to file.*

BUSINESS TYPE	IN BUSINESS MORE THAN 3	IN BUSINESS LESS THAN 3 MONTHS
C-Corps	Form 941 (Quarterly Tax and Wage Report) ***OR*** Most recent payroll report from a third party payroll processing company (e.g., ADP or Paychex)	Most recent payroll report from a third party payroll processing company (e.g., ADP or Paychex) ***OR*** Copy of Business Application and Registration form submitted to RI Division of Taxation and W-4's
S-Corps	Form 941 (Quarterly Tax and Wage Report) ***OR*** Most recent payroll report from a third party payroll processing company (e.g., ADP or Paychex)	Most recent payroll report from a third party payroll processing company (e.g., ADP or Paychex) ***OR*** Copy of Business Application and Registration form submitted to RI Division of Taxation
PARTNERSHIPS	**FOR EMPLOYEES WHO ARE**	**FOR EMPLOYEES WHO ARE**
(General partners will not have Form 941 or W-2. Income information is found on Schedule K-1 – line 15A).	Schedule K-1 (Partner's Share of Income) ***OR*** Schedule SE (Self-employment Tax) ***OR*** Form 1065 (Partnership Return of Income ***AND*** **For employees who are not partners:** Form 941 (Quarterly Tax and Wage Report) ***OR*** Most recent payroll report from a third party payroll processing company (e.g., ADP or Paychex)	Affidavit (for owner/employee not on payroll) and supporting documentation ***AND*** **For employees who are not partners:** Most recent payroll report from a third party payroll processing company (e.g., ADP or Paychex)

Limited Liability Company (LLC)	May file as a C-Corp or a Partnership Determine which one and see requirements above.	May file as a C-Corp or a Partnership Determine which one and see requirements above.
INDEPENDENT CONTRACTORS		
Independent Contractors	Form 1099-MISC	Affidavit (for owner/employee not on payroll) and supporting documentation
FARMS		
	Schedule F (Profit or Loss From Farming)	Most recent payroll report from a third party payroll processing company (e.g., ADP or Paychex) ***OR*** Affidavit (for owner/employee not on payroll) and supporting documentation
NON-PROFIT ORGANIZATIONS		
There are many forms that may be filed under non-profit status. The best way to determine which form is used is to ask the group which form they actually file with the government. Churches/religious organizations may have K-2/W-2 forms even when non-profit.		

Chapter 12: Billing & Late Payments

A. Introduction

This Chapter will detail the policies, procedures and rules governing terminations, billing, and late payment in the HealthSource RI individual and SHOP markets.

B. Termination of Coverage in the Individual Market

Issuers of QHPs (health insurance companies) may not terminate the coverage of any QHP unilaterally.[424,425] Should a health insurance company believe that termination of an enrollee is warranted, it may request that termination be initiated by HealthSource RI by providing notice to HealthSource RI in writing or in such other format as HealthSource RI may determine, but the termination must be completed by HealthSource RI. Upon examination and successful validation of such request, HealthSource RI will initiate such termination and provide notice of termination to the enrollee and the health insurance company.

1) *Involuntary Termination*: HealthSource RI will initiate the termination of an enrollee's coverage in the following circumstances[426]:

- The enrollee is no longer eligible for coverage through HealthSource RI;
- The enrollee did not pay his or her premiums, after the exhaustion of any applicable grace periods;
- The enrollee's coverage has been terminated;
- The QHP terminates or is decertified;
- The enrollee changes from one QHP to another during a qualified enrollment period.

Example: Amy moves out of the state of Rhode Island and reports this change to the exchange. She is no longer eligible for coverage through the QHP. HealthSource RI will terminate her coverage at the end of the month in which she reports this change.

2) *Voluntary Termination*: An enrollee may request to terminate health coverage in a QHP at any time, including because he or she has obtained other minimum essential coverage.[427] An enrollee may terminate his or her coverage through the customer's online account, or by calling or visiting the HealthSource RI contact center. The effective dates of terminations are described in Section D of this Chapter.

C. Notification

Upon termination, HealthSource RI shall provide the customer with a notice of termination as well as any other additional notices, as appropriate depending on the reason for the termination. This notice will include the reason for termination and will be sent at least 30 days prior to the last day of coverage for any form of

[424] 45 CFR 155.430(a)
[425] 45 CFR 156.270(a)
[426] 45 CFR 155.430(b)(2)
[427] 45 CFR 155.430(b)(1)

involuntary termination.[428] Customers who voluntarily terminate their coverage will be disenrolled at the end of the month in which they are making the request and will receive a notice upon completion of the voluntary termination.

Termination notices are always sent by mail, regardless of whether the individual has set his or her notification preference to e-mail. The termination notice will be sent to the primary account contact. If the individual has authorized a representative to make decisions on that individual's account, and the authorized representative's address is listed on the account, then the authorized representative is considered the primary account contact and will receive the termination notice.

D. Effective Dates for Termination of Coverage

Coverage through HealthSource RI is offered in one-month intervals. HealthSource RI is not able to perform mid-month terminations, with the only exception being for the case of death. In all other cases of voluntary termination, the last day of coverage will always be one of the following[429]:

- The last day of the month during which termination is requested by the enrollee; or
- If the enrollee requests a later termination date, then on the last day of the month specified by the enrollee;[430] or
- If enrollee is terminated because of switching from one QHP to another during open enrollment or special enrollment, the last day of coverage in an enrollee's previous QHP is the day before the effective date of coverage in his or her new QHP, including any retroactive enrollments.

In the case of a termination due to the individual becoming ineligible for coverage in a QHP through HealthSource RI, the last day of coverage will be the last day of the month following the month that HealthSource RI sent notification of an eligibility redetermination.[431]

If a QHP enrollee is determined eligible for Medicaid then the last day of QHP coverage is the last day of the month that the enrollee is determined eligible for Medicaid.

In the case of termination due to the death of an enrollee, the last date of coverage shall be the day of the death.[432] For mid-month terminations due to deaths, premiums shall be prorated in accordance with a 30-day prorating rule. The premium payable for that terminated enrollee shall be calculated as follows:

(Total Days of Coverage Received / 30) x Full Monthly Premium

Example: Kevin was paying $240 per month for his premium. If he dies on July 20th, his coverage would be terminated on July 20th and his premium would be pro-rated using the calculation as follows:

[428] 45 CFR 156.270 (b)(1)
[429] 45 CFR 155.430(d)(1)-(2)
[430] An enrollee may not specify a termination date more than three months from the date of the request for termination of coverage.
[431] 45 CFR 155.430 (d)(3)
[432] 45 CFR S. 155.430(d)(7)

(20/30) x $240= $160

The premium payable for Kevin would equal $160.

In the case of a termination due to non-payment of monthly premium: [433]

- If the individual receives APTCs and, as a result, is eligible to receive a 3-month grace period, the last day of coverage will be the last day of the first month of the 3-month grace period.
- For individuals not receiving APTCs, the last day of coverage will be the last day of the 1-month grace period.

Example: Barbara is eligible for APTCs and fails to make a premium payment for May coverage by the April 23 deadline. She has until July 31 to pay the outstanding balance on her account. If no payment is received by July 31, Barbara will be terminated from her plan effective May 30.

Example: Ben is not eligible for APTCs and fails to make a premium payment for May coverage by the April 23 deadline. He has until May 31 to pay the outstanding balance on his account. If no payment is received by May 31, he will be terminated from his plan effective May 30.

For all other cases of involuntary termination, HealthSource RI shall set the effective date of termination in accordance with applicable law.[434]

Example: Megan wishes to voluntarily terminate her coverage, and submits her request to HealthSource RI on May 10th but does not specify a requested termination date. The effective date of termination will be May 31.

Example: Edward has become eligible for Medicaid with a coverage effective date of April 1. His existing coverage will be terminated by HealthSource RI on April 31.

Example: Sandy is re-determined by HealthSource RI to be ineligible for coverage through a QHP, and is notified of this redetermination on September 18. Barring a request to provide additional documentation in support of eligibility, the last day of her coverage will be September 30th.

Example: Deb is enrolled in a QHP that has been decertified, and can no longer purchase coverage through HealthSource RI, HealthSource RI will terminate Deb's coverage. The effective date of the termination will be the last day of the month at which point the QHP will no longer offer coverage. Deb will receive notification of a 60 day time period (a special enrollment period) within which she will be able to select a new QHP.

[433] 45 CFR 155.430 (d) (4)-(5)
[434] 45 CFR 155.430(a)

E. Effective Dates for Termination of SHOP Coverage

Federal regulations grant the SHOP flexibility to determine the timing in which coverage in a QHP may be terminated.[435] Terminations from SHOP coverage shall always be effective on the last day of a month, except in the case of a death of an enrollee, in which case the last day of coverage shall be the date of the death.[436] For mid-month terminations, premiums shall be pro-rated.[437]

F. Retroactive SHOP Terminations

The employer may choose either the last date of the current month, or the last day of the prior month to remove ("terminate") the employee from the SHOP. [438]

G. Billing

HealthSource RI's financial management system is the system of record for transactions related to billing and payment for coverage purchased through HealthSource RI.[439] With the exception of certain special enrollment categories, payment is always due in full in advance of the coverage month to which it is meant to apply.

Example: Danielle signs up for health insurance during Open Enrollment with a requested coverage start date of February 1st. Her plan costs $154. She must pay $154 by January 23rd in order to be considered paid in full for the month of February.

1) Initial Invoices

Initial Invoices are sent during annual open enrollment and during Special Enrollment Periods (SEP). The day after a plan selection has been made, the initial invoice is placed in the customer's online account, and if the customer has selected paper mail as his or her communication preference, the invoice is also mailed to the address on record for the customer (or his or her authorized representative, if one has been selected).

The form and manner of transmission of all subsequent invoices are in accordance with the preference indicated by the customer in the account. Customers who indicate a preference for electronic communication will receive a notice at the email address they provided to alert them when a new invoice is available in their online account.

Invoices have a payment due date of the 23rd of the month. Regulations grant HealthSource RI flexibility to establish a deadline relative to the Annual Open Enrollment Period by which an individual's first month's premium must be received in order to make coverage effective as of the first day of the upcoming coverage year.[440] HSRI may or may not extend the payment deadline in a given Open Enrollment. Customers should

[435] 45 C.F.R. S. 155.735(a)
[436] 45 C.F.R. S. 155.735(a)
[437] 45 C.F.R. S. 155.735(a)
[438] 45 CFR S. 155.735(a)
[439] 45 CFR 155.240(c)
[440] 220-RICR-90-00-1.6(C)

refer to their Open Enrollment notice or www.HealthSourceRI.com for updated information regarding payment dates.

Example: Mariam has made a plan selection on November 20th during Open Enrollment and selected an effective coverage date of February 1. An initial invoice will be generated and mailed to her in December. The payment due date on the invoice will be January 23.

2) Ongoing Invoices

Ongoing invoices for both the individual market as well as SHOP enrollees will be generated monthly with payment being due on the 23rd of the month before the coverage month to which such payment applies. Payment for any given month's premium must be received by the 23rd or customers risk having an interruption to coverage.

Example: Matt is currently enrolled in a QHP through HealthSource RI. An invoice will be generated and mailed to him in early February and the full payment of that invoice will be due on the 23rd of February for the coverage month of March.

H. Payment Options

HealthSource RI will provide customers with several options for paying their bills. Those options are as follows:

- *By mail:* Customers may mail a check or money order with their statement printed from HealthSource RI portal. The check or money order and statement must be mailed to: HealthSource RI, P.O. Box 9711, Providence, RI 02940-9711.
- *One-time and recurring electronic payments (ACH):* Customers can choose to make a one-time electronic payment or sign up for recurring electronic payments. Rules for establishing recurring payments must be followed.
    - Enrollees may be required to set up a new recurring payment schedule for each coverage year, but the Exchange retains the discretion to carry forward recurring payment year from one policy year to another.
    - Customers will receive a confirmation number after making a payment in this fashion and should retain that number for your records.
    - For customers with recurring monthly payment: a notation that customer has recurring payment set up will appear on his or her invoice. If it does not appear on an invoice, customer needs to log into his or her online account or contact HSRI to confirm the payment account information is correct. If the invoice does not show a customer has recurring payments, he or she, will need to make a manual payment by the 23rd to avoid any potential disruptions to the customer's coverage.
- *Directly to health insurance company*: Federal regulations permit enrollees to pay their health insurance company directly if the health insurance company accepts direct payments. Direct payments are discouraged by HealthSource RI, and may require extra processing time and/or result in disruptions to coverage.

- *In person*: Customer wishing to hand-deliver payments can do so at the HealthSource RI Walk-in Center at 401 Wampanoag Trial. The walk–in center can only collect check or money orders; cash or electronic payments will not be accepted at the Contact Center.

It is critical for customers mailing or dropping off a payment to include their account number with their payment to ensure the payment is applied to the correct account. Failure to include this information could result in a disruption of coverage. HSRI will make every effort to reunite a customer with their property, either in the form of a refund or application of funds towards a balance owed. If HSRI is unable to identify the intended account or reach the payer after reasonable efforts, then the unclaimed funds will escheat to the State of Rhode Island as unclaimed property. After this point, HealthSource RI is no longer able to access these funds.

All payments are stored at the account level and applied against balances from oldest to newest. This means that when customers owe outstanding payments for prior months, any payments they make will be applied to outstanding premiums in the order of oldest to newest. For example, where a customer has not paid the full premiums for coverage in April and May, any payments made for June coverage will first be applied to satisfy the April balance, and then applied to satisfy the May balance, prior to being applied to the balance for June coverage.

I. Late Payment

Individuals and employer bills will be considered overdue if they are not paid in full by the 23rd of the month for the proceeding month's coverage and any past due amounts. Special payment deadline rules may be published for the Annual Open Enrollment Period and will be issued on a year-by-year basis dependent upon the circumstances for that year. These deadlines will be included on the Annual Open Enrollment notice and any deadline extensions will be posted on www.HealthSourceRI.com as they are extended. [441]

Customers who are attempting to make a payment for coverage after they have been terminated for non-payment may request a refund by calling the contact center. Note customers who have been disenrolled for non-payment will not be able to enroll in coverage until the next Open Enrollment period unless they experience a qualifying life event.

J. Making a payment

Customers may make payments directly through their online HealthSource RI account. This method is the best way to ensure payments are received in a timely fashion. Customer should not make two payments within the same 24 hours. Doing so could result in cancellation of one, or both, payments.

Valid payment methods include electronic payments (direct withdrawal from customer's account), check, or money order. A recurring payment can be set up after a customer has paid his or her first invoice in full. Customers choosing to pay online, either by using a one-time payment or through a monthly recurring payment, should review the terms and conditions for payments available at the time when they are making

[441] 45 CFR 156.270

the payment. If a customer is making this payment over the phone, the contact center representative will read the terms and conditions to the customer.

Please note, payment is due on the 23rd of the month for the next month's health coverage and payment must be **received** by this date. For payments made by mail, customers should allow enough processing time for the mail to arrive. HSRI will not abide by postmarked dates for payments, as payments must be received by the 23rd in order to ensure there is no disruption to coverage. A customer is considered paid if their initial payment for the year is within $5 of the amount owed, and for subsequent months if the balance owed is less than $10.

K. Balance owed at time of invoice and account changes made after that date resulting in additional amount owed:

Customers should review their monthly invoice to ensure it reflects the correct coverage household and plan selection. Customers who make changes to their account between the time printed on the invoice through the payment due date of the 23rd should log into their online account, or call the contact center, to ensure they are paying the correct amount owed. Many changes can have an impact on balance due for a given month. Customers with recurring payments should confirm they do not owe an additional balance following an account change. **For customers with a recurring payment, if a change is made after the date on the invoice that results in a different amount due compared to what is on the invoice, the recurring payment will withdraw the lower amount in that month. This could result in an interruption to coverage. Customers with recurring payments should check their account balance whenever they make any changes to their account, including updates to income, plan selection or family composition.**

If customers do not pay their full balance by the payment due date their account is at risk of experiencing an interruption in coverage. It is the customer's obligation to make sure they are paid in full by the payment due date.

L. Notification

Individuals electing to receive APTCs who are overdue on their bill will receive a late notice with their monthly invoice.[442] The notice will include the amount overdue and the coverage termination date if the customer does not pay their overdue balance by the deadline. Late notices and intent-to-terminate notices do not show up in a customer's online account and are only sent via mail. Employers and individuals not receiving an APTC and who are overdue have a one-month grace period,[443] and will receive an *Intent to Terminate* notice at least 30 days prior to the termination date[444,445]. Individuals who do not qualify for APTCs and employers who continue to be delinquent 1-month beyond the overdue date will be terminated for non-payment after one month, in accordance with grace period rules.[446,447]

[442] 45 CFR 156.270(f)
[443] RIGL 27-18-3(a)(3)
[444] 45 CFR 156.270(b)(1)
[445] 45 CFR 156.270(f)
[446] 45 CFR 155.430(d)(5)
[447] RIGL 27-18-3(a)(3)

Individuals who qualify for APTCs have a 3-month grace period and will be terminated for non-payment if payment in full is not received by the end of the three month grace period.[448,] Termination will be effective as the of the last day of the first month of the grace period.[449]

Invoices with late payment notification and termination notices will be delivered by mail, regardless of the individual's preference. These notices will be sent to the primary account contact. If the individual has authorized a representative to make decisions on that individual's account, and the authorized representative's address is listed on the account, then the authorized representative is considered the primary account contact and will receive the late payment or termination notice.

Example: Olivia is not eligible for APTCs and she forgot to pay the bill for her March coverage, which was due on the 23rd of February. She will receive a late payment notice including the amount she owes and informing her that her coverage will be end on March 31 if she doesn't pay her outstanding balance by March 23rd.

M. Pending and Unpending Claims During Grace Period Months

In the case of an enrollee receiving APTCs who is delinquent in their premium payment, HealthSource RI will provide a grace period of three consecutive months, as described above. During this grace period, health insurance company actions surrounding any claims incurred by the enrollee are dependent upon the following timeline: [450]

- During the first month of the grace period, the health insurance company will pay all appropriate claims for services rendered to the enrollee.
- During the second and third month of the grace period, the health insurance company *may* pend claims for services rendered to the enrollee. Pending claims mean that the customer may have to pay the full price for the service at the point of service and have the opportunity to submit claims to his or her health insurance company for reimbursement at a later date if premium payment is made for the pended coverage month. If payment is never made for the overdue premium, the individual is eventually termed from coverage in accordance with the dates outlined in Section D. Health insurance companies retain the right to collect upon unpaid premiums for months during which claims for services rendered to the enrollees are paid by the health insurance companies.
- Once a customer has entered their grace period, payment must be made in full, including any past due amount, in order to have coverage unpended. Partial payments will not adjust the grace period months.

N. Automatic Renewal and De Minimus Variations

In the case where a customer has active coverage in a given year, HealthSource RI may notify the customer that he or she is eligible for automatic renewal for the following year. If the customer who has been notified

[448] 45 CFR 156.270(d); 45 CFR 156.270(g); 45 CFR 155.430(d)(4)
[449] 45 CFR 155.430(d)(4)
[450] 45 CFR 156.270(d)(1)

owes less than $5 on the payment due date for January coverage in December, counting the premium for January in the upcoming year, the customer's coverage will automatically renew for January in the upcoming year. The customer will be liable to pay back any tax credits paid out for the month January, and every other month of coverage where they do not pay their full share of the premium. **Customers who have been notified that their coverage will automatically renew for the following year who owe less than $5 and who don't wish to be renewed for January 1st need to request to disenroll by December 31st or they will be automatically renewed into a plan and potentially liable for any tax credits paid on their behalf.**

O. Refunds

Customers with valid credits on their account can request a refund of that credit. The refund request is analyzed and approved or denied by the HSRI research team and must be made by calling the contact center. The customer will be contacted with the results of the research. Refunds cannot be requested until 15 days after a customer payment has been made.

- Refunds must be requested by phone via the contact center. Mailed requests for refunds will not be reviewed.
- If a customer has active coverage and plans to continue with HSRI, he or she is encouraged to apply any overpayments or credit balances to future months of coverage. It is unlikely that a refund would be issued before the next premium is due.If a refund is mailed and the mail is returned, HSRI will look into whether there has been a recent address change for the account. If there is no address change, HSRI will attempt to contact the customer by phone. A new check is issued only at the verbal request of the customer.
- Any uncashed checks that are over three years old may be escheated to Treasury annually. A final notice will be sent to the customer regarding the escheated monies.
- Refund checks are voided after 120 days if uncashed. A permanent stop payment is issued by the Bank.
- If a refund is requested and issued, any subsequent chargeback will be contested.

Refund requests when an account holder is deceased:

- HSRI's policy is that it will honor valid refund requests from an estate's administrator/administratrix or other individual appointed by law. Refund checks are made payable to the estate of the deceased account holder. These refunds can be deposited into the estate of the account holder.
- HSRI cannot change the name on the refund check to that of another person or family member if that person or family member is not an Authorized Representative on the account.

P. Health Insurance Company Assessment Fee

The assessment fee for HSRI shall be expressed as a percentage of premiums and based upon the total premium dollars expected to be collected in a given quarter. On or before each last day of January, April, July, and October, HSRI will generate an invoice to each health insurance company. Invoice amounts will be calculated quarterly, based on premiums for the prior three-month period.The Carrier Exchange handbook

provides more detail regarding the invoicing structure and mechanism to make payments.

Q. Collection After Termination

After the coverage of an individual, family, or employer group is terminated, HealthSource RI will cease with collection activities and allow the health insurance company to directly collect amounts due to it. At this point, should any terminated individual, family, or employer group pay any amounts to HealthSource RI, which is due to the Issuer, HealthSource RI will forward such amounts to the respective health insurance company.

R. Bankruptcy

In the event a customer files for bankruptcy, the end creditor is the customer's respective health insurance company. As further explained in Section Q, above, after the coverage of an individual, family, or employer group is terminated, HealthSource RI will cease with collection activities and allow the health insurance company to directly collect amounts due to it. When HealthSource RI is served with any notice pursuant to Section 362(a) of the Bankruptcy Code, HealthSource RI may forward the notice and its attendant documents to the Issuer.

Chapter 13: HealthSource RI Account Creation & Maintenance

A. Application Process Overview

Customers must complete and submit a HealthSource RI application in order to be eligible to seek coverage through HealthSource RI.

During Annual Open Enrollment or during a special enrollment period, individuals may apply for coverage through HealthSource RI:

- Online at:
  - www.HealthSourceRI.com
  - www.HealthyRhode.ri.gov

- By phone: at 1-855-840-4774
- In person at: 401 Wampanoag Trail, East Providence, RI 02915 (Monday through Friday from 8:00 am – 7:00 pm)
- By completing and submitting a paper application to: HealthSource RI HZD Mailroom 74 West Road, Suite 900 Cranston, RI 02920-8413

For more information about the Annual Open Enrollment period and special enrollment periods, see Chapter 3.

1) Completing the Application

Completing the Application is the first step in the process of getting coverage. The application helps HealthSource RI determine program eligibility, including whether the applicant may be eligible for:

- Government-sponsored coverage from Rhode Island Medicaid or RIte Care
- Qualified Health Plans (QHP)
- Tax credits and/or Cost-Sharing Reductions (CSRs) to make QHP coverage more affordable

When applying, individuals should have the following information and documents readily available for all members of their household who need health coverage:

- Social Security numbers (required only if applicant has a SSN)
- Birth dates
- Passport, alien, or other immigration numbers for any legal immigrants
- Previous tax returns, income information for all adults and all minors under age 19 who are required to file a tax return
- Information about health coverage available to your family
- W-2 Forms
- 1099 Forms

- Employer health insurance information, even if applicants are not covered by their employer's insurance plan

Customers may be asked to provide some of this information for members of their household who are not seeking health coverage. Eligibility for certain financial assistance requires information from all people in the household, not just those who are seeking coverage.

B. Enrolling in Health Coverage

The application process is separate from the plan selection and enrollment process. Completing and submitting an application does not automatically allow a customer to select a plan through HealthSource RI. In other words, the application process helps HealthSource RI to determine whether an individual is **eligible** to enroll in qualified health plan with or without financial assistance or RIte Care (Medicaid). For more information about financial assistance, offered in the form of APTCs and CSRs, see Chapter 4.

After the application has been submitted and reviewed by HealthSource RI, and the applicant has been determined eligible to enroll in a QHP through HealthSource RI, the applicant may select, enroll in, and pay for a plan. For more information about eligibility to enroll in plan through HealthSource RI, see Chapter 2. Applicants must select a date for their coverage to start and pay for it by the due date. Generally, payments are due by the 23rd of the month to start coverage on the first of the next month. If the applicant misses the payment deadline, then his or her enrollment will be cancelled and coverage will not start. The applicant must then resubmit his or her application for coverage and select a new start date.

1) Provider Directories

Before choosing a plan, customers should make sure any primary care provider (PCP), specialist(s), and/or behavioral health provider(s) who are important to them or their family members participate in the specific plan network. HSRI strives to ensure that the information made available to customers using the HSRI Provider Directory tool is accurate, however, the only way customers can be certain is if they call their doctors to ask if they are in a specific plan's network. Customers should also call their health insurance company and ask if a desired provider is still in-network before they receive care. HSRI offers its Provider Directory tool as a reference to customers comparing plans, but does not assume liability for any errors or omissions present.

C. Notices

HealthSource RI is obligated to communicate important health coverage information and eligibility determinations to customers by notices. Common reasons for notices include:

- Notification of changes in eligibility for coverage, APTCs and/or CSRs
- Notification that HealthSource RI needs more information to determine eligibility for coverage;
- Notification that HealthSource RI has found a discrepancy in data sources and needs more information from customer regarding current eligibility;

- Notification of eligibility for a special enrollment period;
- Notification of enrollment in a health plan;
- Notification that a customer is late in paying a monthly premium;
- Notification of disenrollment from a health plan;
- Notification regarding the Annual Open Enrollment Period

Any notices required to be sent by HealthSource RI to applicants and customers must include

- Contact information for available customer service resources;
- An explanation of appeal rights, if applicable; and
- A citation to or identification of the specific regulation supporting the action, including the reason for the intended action.[451]

During the application process, individuals have the opportunity to decide how they want to receive notices: electronically or by mail. Notices will be sent by the means specified by the user, however there are some notices that must be sent by mail. For this reason, it is essential that customers maintain and up to date mailing address, even if they select e-mail as their preferred communication method. Customers have an obligation to report any change in address to HSRI and should report such a change as soon as possible to avoid any potential disruption to their health coverage.

Applicants who choose to receive notices by mail will receive correspondence at the mailing address provided during the application process. That mailing address can be changed within the user's account at any time in the "Account Info" Tab under "Contact information".

Applicants who choose to receive notices electronically or by paper will find a log of all notices sent in their HealthSource RI account under the "Notices" tab. E-mail customers will also receive an email notification at the email address in their account alerting them that a notice has been added to their account. Users may update the email address within the user's account at any time in the "Account Info" Tab under "Contact information". **Users should ensure e-mail notifications are not filtered into "spam" folders, as these notices are critical communications from HealthSource RI.**

Customers may change their communication preference at any time within their HealthSource RI user account in the "Account Info" Tab under "Contact Information".

For all HealthSource RI customers, "late notices" - i.e., billing statements (invoices) sent to customers after the monthly premium payment deadline informing them that they are late in making a payment - will always be sent by mail, regardless of the customer's preference. For customers in the individual market, billing statements are sent via U.S. postal service. For customers in the SHOP market, billing statements are sent via the customer's communication preference. See Chapter 12 for more information about billing and premium payment deadlines.

[451] 45 CFR 155.230(a)

D. Selecting an Authorized Representative

During the application process, the primary account contact may select to have an "Authorized Representative" assigned to their account. An Authorized Representative is a third-party individual authorized by the primary account contact to be the primary point of contact on the account. The authorized representative must be 18 or older and can be a friend, relative, or anyone else chosen by the applicant.

The Authorized Representative can access the customer's account, make decisions regarding the account, make premium payments on the account, and will receive all notices and invoices on the customer/enrollee's behalf. **The customer will not receive any notices or invoices if an Authorized Representative has been selected, though the customer always has access to his or her online account where notices and invoices may be viewed at any time**

Selecting an Authorized Representative is optional. Users may consider selecting an Authorized Representative if they need or would like help making sure they are aware of important notices or bills sent by HealthSource RI.

1) Authorized Representative Appointed by Law

An Authorized Representative can also be someone who has been appointed by law to act on a customer's behalf. An authorized representative appointed by law may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the estate's administrator or executor. Prior to engaging with an authorized representative in any substantial way regarding a customer account, an Authorized Representative appointed by law must submit to HSRI a copy of the applicable legal document stating that he or she is lawfully representing the customer in question. A person appointed by law to act on behalf of the estate of an applicant or member who has died can also serve as an authorized representative by following the instructions above. The exact authority of an Authorized Representative may depend upon the wording of the relevant legal document.

2) Limited Use Authorized Representative

A Limited Use Authorized Representative (LUAR) serves a similar, but reduced, function as an appointed Authorized Representative described above. They can perform the same functions as an Authorized Representative, including making changes to an account and communicating with the call center on behalf of a primary account contact, however a LUAR will NOT receive the notices and invoices associated with an account. A LUAR can be appointed by completing the appropriate form and instructions as available on www.HealthSourceRI.com. These requests must be made by using the form available and following the instructions on the form for submission. These requests **may not** be made over the phone or in-person.

E. Change Reporting

During the coverage year, customers may experience life changes that impact eligibility for coverage through

HealthSource RI. Customers should inform HealthSource RI if:[452]

- Their household income changes (goes up or down);
- They move;
- They become incarcerated;
- There is a citizenship or immigration status changes for any household member; or
- Their family size changes--for example because of marriage, divorce, birth, adoption, or death.

Customers receiving Medicaid and CHIP must report changes to any of the above within 10 days,[453] while those enrolled in a QHP with or without financial assistance, must report within 30 days of such change.[454]

It is critical that customers report these changes within the timeframes outlined above. Some changes may impact eligibility for coverage and/or financial help. Some changes, if not reported, may impact customers' tax credit reconciliation at the end of the tax year. Please see Chapter 8 for a complete list of changes customers must report to HealthSource RI and/or DHS, and the ways in which customers can report those changes.

Note: If a QHP enrollee did not request to be considered for insurance affordability programs when the customer applied for coverage (i.e., indicated he or she was not interested in financial assistance), the enrollee is not required to report any information related to IAP eligibility, but is still required to report changes impacting eligibility for HealthSource RI coverage, for example change in address or incarceration.[455]

F. Applicant Rights & Responsibilities

In accordance with federal and state law and U.S. Department of Health and Human Services (HHS) policy, HealthSource RI is prohibited from discrimination on the basis of race, color, national origin (limited English proficiency persons), age, sex, disability, religion, gender identity or political beliefs.
To file a complaint of discrimination, customers may contact HHS at HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

HealthSource RI and the Rhode Island Executive Office of Health and Human Services (EOHHS) (the State Medicaid Agency) must:

- Help customers fill out all requested forms
- Provide interpreter or translator services at no cost when a customer is communicating with HealthSource RI or EOHHS.

[452] 45 CFR 155.330(b)(1); 42 CFR 435.916(c)
[453] 42 CFR 435.916(c)
[454] 45 CFR 155.330(b)(4)
[455] 45 CFR 155.330(b)(2)

1. Interpreter and translator services are available:

English
If you, or someone you're helping, has questions about Healthsource RI, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-855-840-4774.

Spanish
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Healthsource RI, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-840-4774.

Portuguese
Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Healthsource RI, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-855-840-4774.

Chinese
如果您，或是您正在協助的對象，有關於 Healthsource RI 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-855-840-4774。

French Creole
Si oumenm oswa yon moun w ap ede gen kesyon konsènan Healthsource RI, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-855-840-4774.

Mon-Khmer, Cambodian
ប្រសិនបើអ្នក ឬនរណាម្នាក់ ដែលអ្នក កំពុងជួយ មានសំណួរអំពី Healthsource RI ប, អ្នក មានសិទ្ធិទៃ ួលជំនួយនិងព័ត៌មាន ជៅកនុងភាសារបស់អ្នក ោយម និនអស ់ប ាក ់។ បើមប ីនិយាយជាម ួយអ្នក ករកដប្រស ូម 1-855-840-4774 ។

French
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Healthsource RI, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-855-840-4774.

Italian
Se tu o qualcuno che stai aiutando avete domande su Healthsource RI, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-855-840-4774.

Arabic
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Healthsource RI فلديك الحق يف الحصول عىل املساعدة واملعلومات الرضورية بلغتك من دون اية تكلفة. للتحدث مع مرتجم اتصل ب 1-855-840-4774

Russian
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Healthsource RI, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-840-4774.

Vietnamese
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Healthsource RI, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-840-4774.

Kru
I bale we, tole mut u ye hola, a gwee mbarga inyu Healthsource RI, U gwee Kunde I kosna mahola ni biniiguene I hop wong nni nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-855-840-4774.

Ibo
Ọ bụrụ gị, ma o bụ onye I na eyere-aka, nwere ajụjụ gbasara Healthsource RI, I nwere ohere iwenta nye maka na ọmụma na asụsụ gị na akwu gị ụgwọ. I chọrọ I kwụrụ onye-ntapịa okwu, kpọ 1-855-840-4774.

Yoruba
Bí ìwọ, tàbí ẹnikẹni tí o n ranlọwọ, bá ní ibeere nípa Healthsource RI, o ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ongbufọ kan sọrọ, pè sórí 1-855-840-4774.

Polish
Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Healthsource RI, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-855-840-4774.

G. Applicant Responsibilities for All Health Coverage Programs

During the application process, individuals applying for health coverage, including Rhode Island Medicaid, Advance Premium Tax Credits (APTC) and Cost Sharing Reductions (CSR), must provide the Social Security number (SSN) for everyone in the household who has an SSN, including the applicant.[456]

If requested by the agency, applicants must provide any information or proof needed to determine eligibility.

H. Important Rules for All Health Coverage Programs

There are certain state and federal laws that govern the operation of HealthSource RI and EOHHS, which administers RIte Care (Medicaid), customer rights and responsibilities, and the coverage obtained through

[456] 45 CFR 155.305 & 42 CFR 435.910

HealthSource RI and EOHHS. By filling out the HealthSource RI application, applicants agree to comply with these laws and coverage obtained hereby.

1) Customers must provide the Social Security number (SSN) for anyone in their household, including themselves, who applies for health coverage, including Rhode Island Medical Assistance , Advance Premium Tax Credits (APTC) and Cost Sharing Reductions (CSR), under Federal Law (45 CFR 155.305 and 42 CFR 435.910). SSNs are used to check identity, citizenship, alien status and income as well as prevent fraud and verify health care claims. HealthSource RI also uses SSN information with other federal and state agencies, including the Internal Revenue Service, to manage our programs and follow the law.

2) If requested by the agency, customers must provide any information or proof needed to determine if they are eligible for coverage or financial help. Customers must report changes in income, family size or other application information as soon as possible.

3) Requirement to provide voter registration assistance

The National Voter Registration Act of 1973 requires all states to provide voter registration assistance through their public assistance offices. Applying to register or declining to register to vote will not affect the services or benefits customers may receive from HealthSource RI. Customers can register to vote at: http://www.elections.ri.gov/voting/registration.php.

4) Right to appeal

Customers may ask for an appeal. If a customer disagrees with a decision that was made by HealthSource RI regarding eligibility, he or she has a right to appeal that decision. Pursuant to EOHHS Rule 210-RICR-10-05-2, "Appeals Process and Procedures for EOHHS Agencies and Programs", customers may file an appeal of an eligibility determination and the matter will be heard by a hearing officer. More information about appeals rights and the appeals process may be found in Chapter 9.

Personal information will be protected as described in the HealthSource RI Privacy Policy, which may be made available to you upon request. Contact HealthSource RI to request a copy. This policy is available on our website (www.healthsourceri.com) to review at any time.

5) HealthSource RI is not responsible for administering commercial health plans

Questions about the terms of a health insurance plan, including benefit eligibility, out of pocket expenses under a plan, and making a benefit claim or appealing a denial of benefits, should be addressed to the health insurance company. Health insurance companies will provide individuals with more information about plan benefits. Assistance with such inquiries and appeals may be obtained through the Rhode Island Office of the Health Insurance Commissioner (OHIC) at 855-747-3224.

If an individual is eligible for COBRA following the termination of any health insurance coverage, the former employer or issuer is responsible for administering COBRA and providing the required COBRA notices and election period.

Individuals should not cancel any current insurance coverage or decline any COBRA benefits until they have received an approval letter and insurance policy, also known as insurance contract or certificate, from the insurance company selected during the enrollment process. Individuals should make sure they understand

and agree with the terms of the policy, and pay special attention to the effective date, waiting periods, premium amount, benefits, limitations, exclusions, and riders.

I. Requirements of Qualified Health Plan (QHPs) Enrollees Only

A. Responsibility to report changes affecting eligibility

Individuals who enroll in a qualified health plan through HealthSource RI and have a change in income must notify HealthSource RI within thirty (30) days of that change. A change in income could change the tax credits or cost-sharing reductions a customer is eligible to receive. The tax credit is based on the estimated income the applicant submits on the application. Generally speaking, if a customer's income goes up, he or she will qualify for less tax credits. If an individual does not report a change in income, HealthSource RI has no way of knowing about this change, and will continue to provide the same tax credit for each month that the income change is not reported, and the individual may have to pay that money back at tax time. Please refer to Chapter 5 for more information regarding tax credit reconciliation.

B. Plan rates and benefits

Premium rates are subject to change based on the health insurance company's underwriting practices and the customer's selection of available optional benefits, if any. Final rates are approved by the Health Insurance Commissioner.

Premium rates are for the requested coverage effective date *only***.** If the actual effective date of a customer's policy is different from the requested effective date provided on the application, the cost of the policy may differ from the rates quoted on HealthSourceRI.com. This is potentially due to rate increases or policy changes from the insurance company and/or one or more family members having a birthday occur in the interim--rates are calculated based on age. The customer's chosen health insurance company may not guarantee its rates for any period of time until a contract is signed.

J. HealthSource RI Application Policies

Throughout the course of application and enrollment through HealthSource RI, individuals receive descriptions of HSRI's application policies and are asked for consent regarding the following:

- **User Acceptance agreement –** By agreeing to this User Acceptance Agreement, applicants accept terms and conditions of applying for coverage, including the terms of our Privacy Policy.
- **Sharing of Data** – A consent form signed by the applicant giving permission for HealthSource RI to obtain, use and share confidential information about the applicant for the sole purpose of determining the applicant's eligibility.
- **Consent for Use of Income Data** - In order to determine applicants' eligibility for help paying for their health coverage, HealthSource requires applicants' consent to access their income data, including information from tax returns.
- **E-signature** - By signing the application electronically, applicants certify and attest under penalty of perjury that the information included in their application is correct, including information about citizenship and alien status, and complete to the best of their knowledge.

- **Consent for ID Proofing -** To protect applicants' privacy, applicants will also need to successfully complete Identity Verification before establishing an online account with HealthSource RI.
- **Consent for payment—**Customers who wish to pay by e-check on a one-time, or recurring, interval will be asked to consent to the terms and conditions for doing so.

These policies may be periodically updated and are available at healthsourceri.com/application-policies/ for review at any time.

K. Working with Navigators & Certified Application Counselors

Navigators and Certified Application Counselors are located across the state to help individuals consider their health insurance options, complete an application, and enroll in a plan that best fits their needs. They are also available to assist customers with filing appeals or complaints. They provide in person assistance only for individuals and families.

1) Reach out to a Navigator.

HealthSource RI has over 100 certified and trained Navigators available for in person assistance by appointment. Search the full list (https://healthyrhode.ri.gov/HIXWebI3/DisplayNavigatorSearch) by location, hours of service, and language preference. Many of our Navigators are fluent in languages other than English and also offer assistance to customers who are deaf or hard of hearing. Interpreter services can be arranged through our Contact Center for anyone who needs assistance in other languages not offered by existing navigator agencies.

2) Meet with a Certified Application Counselor.

The Certified Application Counselor Program is a volunteer program for agencies interested in providing unpaid, in person application assistance to consumers who want to enroll in health insurance through HealthSource RI. Certified Applications Counselors (CACs) may only provide in-person assistance. CACs should display their certificate at all times and note their certification number on the enrollment application when working with a customer. Customers should sign a written consent form (available in English or Spanish) and provide every consumer with a handout, which provides information on how to follow up on the appointment and report any concerns. CACs may never, under any circumstances, retain any personal information or account information or access customer accounts while they are not in-person with the counselor. The relationship remains at the discretion of the customer, not the CAC.

CACs have volunteered to be trained and certified by HealthSource RI. They are located in agency settings across the state. Review the full list of Counselors and participating agencies here: (http://www.rihca.org/about-rihca/outreach-and-enrollment.aspx).
For agencies interested in training CAC's:

There will be no form of payment from HealthSource RI, or any other entity, to the agency or the Certified Application Counselor for this work. Certified Application Counselor agencies must commit to training a minimum of two individuals in order to be considered as a Certified Application Counselor Agency

Agencies interested in becoming Certified Application Counselor entities should review the application and

guidelines available at: http://www.rihca.org/about-rihca/get-certified.aspx.

3) All assistance is in-person only.

One narrow exception to this general rule is that Navigators are able to assist if an individual who needs to follow up after the in-person appointment on a verification or other task with the HSRI Contact Center over the phone. Both the Navigator and the Customer would need to be on the phone together in order for the contact center to have permission to assist the customer. This option is not available for Certified Application Counselors.

Under no circumstances may a Navigator call the HSRI Contact Center to discuss a particular consumer's account without the consumer in person or, in the case of the exception above, on the phone.

In-home application or enrollment assistance can occur if the consumer asks for it and provides consent.

4) Confirm that the Navigator or Counselor is certified.

All Navigators and Counselors must display their certificate when working with a customer. Navigators use this certification number to obtain an account with HealthSource RI where they maintain a "Navigator dashboard" with names and account links for all consumers who agree by written consent as well as online consent to link their individual account with the navigator's dashboard. Navigators and Counselors are also required to ask individuals to sign a consent form.

Under no circumstances should individuals seeking assistance from a Navigator or a CAC be asked for payment. Such services are provided free of charge to all individuals.

Navigators will have access to the individual's account for the duration of the agreed partnership. Linking individual accounts with Navigators is a customer-driven function which allows the individual to end the linkage at any time, change the link to a different Navigator, and/or change the duration of the linkage at any time through their online HSRI account. However, Navigators are instructed to access the individual's account only in the presence of the individual.