

HealthSource RI Policy Manual

Plan Year 2026



HealthSourceRI
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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 marketplaces to facilitate households’ purchases of affordable health insurance coverage through a marketplace.
- Creating new federal Advance 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 that households below 250% of the Federal Poverty Level (FPL) face when using their health insurance plans.
- Expanding Medicaid for adults without children up to 133% of the 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 passed, and Governor Gina Raimondo signed, an operating budget containing a provision establishing HealthSource RI (HSRI) as a division of the Rhode Island State Department of Administration. HSRI’s organic statute is codified at Rhode Island General Laws, Chapter 42-157, Rhode Island Health Benefit Exchange (with later HSRI-related provisions added in Chapter 52-157.1). HSRI’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 HSRI as the state’s first ever health insurance marketplace. HSRI allows households to apply for and purchase health insurance, apply for APTCs to lower the costs of insurance, apply for an exemption from the shared responsibility payment, or apply for Modified Adjusted Gross Income (MAGI) Medicaid coverage. Small businesses can purchase coverage for their employees through HealthSource RI for Employers.

Since the establishment of HSRI, Rhode Island has developed an integrated approach to health reform under the ACA, incorporating HSRI 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 and the Department of Human Services 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 subsidies, small employers and their employees, and employees of large

¹ The effective eligibility level is 138% FPL due to a 5% disregard.

employers.

HSRI 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 HSRI 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 HSRI, 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 HSRI, including, but not limited to:

- Determining eligibility for Qualified Health Plans,
- Determining eligibility for Advance Premium Tax Credits and cost-sharing reductions,
- Guidelines for enrolling and disenrolling 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

Eligible individuals may enroll in a health insurance plan through HealthSource RI (HSRI). All health insurance plans offered through HSRI 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 HSRI 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 ten 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 EHBs. 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 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 HSRI.⁵ There are certain requirements that individuals must meet to be considered a Rhode Island resident, and these requirements vary slightly for children (ages 0-20) versus adults (ages 21 and older).

i. Adults Twenty-One (21) Years Old and Over

Individuals twenty-one (21) and older 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 HSRI 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 adult who recently graduated from college is living with various friends in Providence while looking for a job. Even though the individual does not have a fixed address, they are in the state presently, and seeking employment. This individual therefore qualifies as a Rhode Island resident and is eligible to purchase a QHP through HSRI.

ii. Children Under Age 21

Individuals under the age of twenty-one (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 HSRI 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 CFR § 435.403(g).

¹² As addressed in 42 CFR § 435.403(f).

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

For individuals who live in an institution¹⁴, 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 Marketplace Areas

In general, if a tax filer is a Rhode Island resident, all members of their tax household may enroll in a QHP through HSRI. 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 a Marketplace 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 Marketplace, their tax dependent(s) may **only** enroll in a QHP through the same Marketplace **or** through the Marketplace that services the area in which the tax dependent resides.

Example: Consider a married couple with a dependent who goes to college in New York. One spouse lives in Rhode Island and the other lives in Washington, D.C. The couple enrolls in a QHP through HSRI. Their dependent has two options: 1) The dependent can enroll in a QHP through HSRI; or 2) the dependent can enroll in a QHP through New York's Marketplace. However, the dependent cannot enroll in the D.C. Marketplace even though one parent is a resident of D.C. because both parents are already enrolled through Rhode Island's Marketplace, HSRI.

c. Treatment of Temporary Absences

For individuals otherwise meeting the residency requirements to be eligible to purchase a plan through HSRI, 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.

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)

- Military service
- Hospitalization

Example: An early retiree (under age 65) lives in Rhode Island but spends the winter in Florida. This individual may enroll in a QHP offered through HSRI even though the retiree will be temporarily out of Rhode Island 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 HSRI and be evaluated for eligibility for APTCs.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 ACA if this individual is a “qualified” immigrant or is 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” or “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 their Spouse, Child, Sibling or Parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture

¹⁸ 45 CFR § 155.305(a)(1)

¹⁹ 8 USC § 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.

- Individual with Non-immigrant Status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status
- Deferred Enforced Departure
- 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 Samoa²²
- Deferred Action Status (Deferred Action for Childhood Arrivals/DACA) was an eligible immigration status for applying for a Qualified Health Plan (QHP) through HSRI **only** for plan years 2024 and 2025.

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 2.1* below.²³

Table 2.1 - 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)
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
Certificate of Eligibility for Exchange Visitor (J-1) Status
Notice of Action (I-797)
Other documents or status types

c. 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 if they are not otherwise able to access health services through a correctional institution.

C. Non-Discrimination

Health insurance carriers may not, with respect to any QHP, discriminate on the basis of race,

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)

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 of HSRI, except as specifically permitted by applicable laws and regulations.

²⁵ 45 CFR § 156.200(e)

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

A. Introduction

This Chapter will detail annual Open Enrollment Periods, Special Enrollment Periods, and enrollment effective dates for HealthSource RI's (HSRI) Individual Market.²⁶

B. Overview of Enrollment in the Individual Market

HSRI provides a specified period of time each year called an "Open Enrollment Period" (OEP) during which qualified individuals and their dependents can enroll in a Qualified Health Plan (QHP). Individuals must sign up and make a timely payment for their first month's premium during an annual OEP to be covered for the upcoming coverage year.

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

There are also "Special Enrollment Periods" (SEPs) that allow individuals and their dependents to select a plan outside of the annual OEP. In order to be eligible for an SEP, individuals must have experienced a Qualifying Life Event (QLE) described in [Section D](#) of this chapter.

C. Annual Open Enrollment Period

1) Overview of Annual Open Enrollment Period

During the annual OEP any qualified individual may enroll in a QHP for the upcoming coverage year. Members of the same household²⁷ who are eligible for a QHP may select and enroll in the same coverage.

HSRI 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 OEPs last a minimum of thirty (30) days.²⁹ The "start" and "end" dates for each annual OEP period are set each year via federal regulation and/or state authority.³⁰

2) Effective Dates for Coverage Purchased During Annual Open Enrollment³¹

Qualified individuals must select a QHP, and HSRI must receive the first month's premium in full by the required date, in order to make coverage effective.³² HSRI establishes a deadline each year relative to the annual OEP 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.³³

During each annual OEP, HSRI will notify enrollees of the plan selection and payment deadline(s) for coverage to begin January 1st of the upcoming coverage year.

Applicants may make changes to their plan selection at any time during the annual OEP and such changes will be effectuated by HSRI in accordance with the coverage effective dates described in

²⁶ See Chapter 11 for information regarding HealthSource RI for Employers 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 45 CFR 155.410(e)

³¹ 45 CFR 155.410(f)(3)(ii)

³² 220-RICR-90-00-1.6(C)

³³ 220-RICR-90-00-1.6(C)

this Chapter.

Note: The example below assumes an annual OEP beginning on November 1st. Annual OEP timeframes are subject to change each year.

Example: Consider an enrollment selection made, and payment received on November 20th during an Annual OEP. The earliest effective date of coverage would be January 1st of the upcoming coverage year, however a customer could select a coverage start date of February 1st or March 1st if desired.

D. **Special Enrollment Periods**

Individuals and families may be eligible to enroll in a QHP through HSRI outside of annual OEP as a result of a QLE.³⁴ Unless otherwise stated, SEPs will last sixty (60) days.³⁵ There are multiple categories of acceptable QLEs, including:

- 1) *Loss of health coverage.* The qualified individual or their dependent:
 - a. Loses minimum essential coverage (MEC);
 - b. Loses pregnancy-related coverage; **or**
 - c. Loses medically needy coverage.

In each of the circumstances described above, the individual or their dependent has sixty (60) days after the loss of coverage to select a QHP.³⁶ 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) *Pregnancy.* A qualified individual who is pregnant may enroll in coverage at any time after the commencement of pregnancy. The effective date of coverage will be the first day of the month in which the qualified individual applies for coverage.³⁷
- 4) *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 an SEP as a result. Note that documents for verification of death are required if the person who passes away is the primary account contact and is discussed more in [Chapter 7](#).
- 5) *Change in lawful status.* The qualified individual, or their dependent, gains status as a citizen, national, or lawfully present individual.
- 6) *Enrollment error by HSRI's determination.* The qualified individual's (or their 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 HSRI, its instrumentalities, or a non-HSRI entity providing enrollment assistance or conducting enrollment activities.³⁸

³⁴ 45 CFR § 155.420(d)

³⁵ 45 CFR § 155.420(c)

³⁶ 45 CFR § 155.420(c)

³⁷ RI Gen. Laws § 42-157-15

³⁸ In such cases, HSRI may take such action to correct or limit the effects of the error, misrepresentation, or inaction.

- 7) *Substantial violation.* The enrollee, or their dependent, adequately demonstrates to HSRI that the QHP in which the individual is enrolled substantially violated a material provision of its contract with the enrollee.
- 8) *Change in insurance affordability program (IAP) eligibility.* The qualified individual or dependent enrolled in a QHP, an eligible employer-sponsored plan, or individual coverage becomes newly eligible or ineligible for Advance Premium Tax Credits (APTCs), or experiences a change in eligibility for cost-sharing reductions (CSRs).³⁹ An enrollee is not considered newly APTC-eligible when they become eligible for \$0 APTC after having previously been APTC-ineligible for another reason, such as having other minimum essential coverage.⁴⁰
- 9) *Permanent move.* The qualified individual or enrollee, or their dependent, gains access to new QHPs following a permanent move.
- 10) *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.
- 11) *Exceptional circumstances.* The qualified individual or enrollee, or their dependent, demonstrates to HSRI, in accordance with guidelines issued by Health and Human Services (HHS), that the individual meets other exceptional circumstances as HSRI may provide.
- 12) *Loss of dental coverage.* HSRI 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 eligibility criteria as described elsewhere, Customers must call the HSRI Contact Center to apply for dental coverage only to utilize this triggering event.
- 13) *Domestic abuse or spousal abandonment.* If an individual is a victim of domestic abuse or spousal abandonment or a dependent or unmarried victim within a household, is enrolled in minimum essential coverage, and is seeking to enroll in coverage separate from the perpetrator of the abuse or abandonment, they are eligible for an SEP. Additionally, a dependent of a victim of domestic abuse or spousal abandonment, applying on the same application as the victim, may enroll in coverage at the same time as the victim.
 - a. Domestic abuse is defined as physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate, and intimidate, or to undermine the victim's ability to reason independently. All the facts and circumstances are considered in determining whether an individual is abused, including the effects of alcohol or drug abuse by the victim's spouse. Depending on the facts and circumstances, abuse of an individual's child or other family member living in the household may constitute abuse of the individual.⁴¹
 - b. An individual is a victim of spousal abandonment if, taking into account all facts and

³⁹ 45 CFR § 155.420(d)(6)

⁴⁰ If an enrollee is eligible for \$0 APTC, it is equivalent to being ineligible for APTC; see 86 FR 24140

⁴¹ 26 CFR § 1.36B-2 (b)(2)(iii)

circumstances, the individual is unable to locate their spouse after reasonable diligence.⁴²

Note: For an individual to be enrolled into coverage during an SEP, the first month's premium is due by the last day of the SEP.

Example: An individual loses their job and health insurance on April 15th. They will be given a 60-day SEP to seek coverage in a QHP. The SEP will end on June 15th and they 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 and gained official refugee status on June 18th. This resident would be entitled to a 60-day SEP to seek coverage in a QHP beginning June 18th.

Example: An American Indian, as defined by Section 4 of the Indian Health Care Improvement Act, wishes to enroll in a new QHP. This individual 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 their new income. If a new eligibility determination was made on August 12th, this customer would have 60 days from August 12th 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 HSRI, the initial or annual OEP closes. This enrollee may be granted an SEP based on exceptional circumstances determined by HSRI.

E. Special Enrollment Effective Dates

1) Overview

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 this section, for example birth.

2) 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 SEP 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:*⁴³ 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:*⁴⁴ HSRI must ensure coverage for the surviving family members on the first day of the month following plan selection (HSRI may also allow such enrollees or their dependents to select a standard enrollment effective date).

⁴² 26 CFR § 1.36B-2(b)(2)(iv)

⁴³ HSRI policy deviates from 45 CFR § 155.420(d)(7), under which the coverage start date is the first of the month following plan selection.

⁴⁴ 45 CFR § 155.420(b)(2)(vi)

Example: An individual moves to RI and selects a plan on August 8th, during the SEP. The earliest coverage start date is September 1st and the bill is due by August 23rd.

3) Special Effective Coverage for Special Enrollment Effective Dates

For certain QLEs, the effective date of coverage may deviate from the general standard. The following is a list of QLEs that entitle individuals to SEPs with unique effective coverage dates:

- a. *Loss of MEC:*⁴⁵ For individuals who lose MEC, including becoming ineligible for employer-sponsored insurance, the effective date is the first day of the month following loss of coverage.
 - o *Special Rule for Mid-month Loss of Coverage:*⁴⁶ If an individual will be losing MEC mid-month, HSRI may permit an alternate coverage effective date beginning the first day of the month in which the loss of coverage will occur to prevent any gap in coverage. Individuals must call HSRI directly to request this alternate effective date **and** select a plan no later than the last day of the month prior to the month the qualifying event will occur, otherwise coverage will begin the first day of the month following the QLE.
 - o *Special Rule for Loss of Medicaid or CHIP Coverage:*⁴⁷ Individuals losing Medicaid or CHIP minimum essential coverage may be eligible for an extended 30-day SEP following a Medicaid or CHIP termination if, while attempting to renew their Medicaid or CHIP coverage, they missed their initial 60-day SEP window.
- b. *Birth, Adoption, Placement for Adoption/Foster Care, Child Support Order/Court Order:*⁴⁸ Coverage is generally effective on the date of the birth, adoption or placement for adoption or foster care. However, HSRI may also permit eligible individuals to select an alternative coverage effective date of the first day of any of the next three (3) months following the QLE.
- c. *Pregnancy:* Coverage is effective no earlier than the first day of the month in which the applicant applies for coverage.
- d. *Marriage:*⁴⁹ HSRI must ensure a coverage effective date for the enrollee on the first day of the month following the marriage.
- e. *Other Special Effective Dates:*⁵⁰ In the following situations, coverage effective dates are determined by HSRI based on appropriate circumstances of the scenario, but SEPs may never be longer than 60 days:⁵¹
 - 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 HSRI, its instrumentalities, or a non-HSRI entity providing enrollment assistance or conducting enrollment activities;
 - ii. The enrollee or dependent adequately demonstrates to HSRI that the QHP the

⁴⁵ HSRI 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.

⁴⁶ 45 CFR § 155.420(b)(2)(iv)

⁴⁷ 45 CFR § 155.420(c)(6)

⁴⁸ 45 CFR § 155.420(b)(2)(i)

⁴⁹ HSRI policy deviates from 45 CFR § 155.420(b)(2), under which the coverage start date is the first of the month following plan selection.

⁵⁰ 45 CFR § 155.420(b)(2)(iii)

⁵¹ 45 CFR § 155.420(c)(3)

individual is enrolled in substantially violated a material provision of its contract with the enrollee;

- iii. The eligible individual, enrollee, or dependent, demonstrates to HSRI, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as HSRI may provide;
- iv. HSRI 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-HSRI entity providing enrollment assistance or conducting enrollment activities.

Example: A child is born on July 24th. The parents complete the child’s enrollment and pay their monthly premium on August 18th. The effective date of coverage for the new baby would be July 24th and any APTC or CSR would be applied as of August 1st. The parents could also choose to have August 1st, or September 1st as the newborn’s coverage start date, with any APTCs or CSRs becoming effective on that day.

Example: An HSRI enrollee gets married on November 20th. This individual adds their new spouse to their plan on December 20th and pays the premium for the first month of coverage on December 22nd. The new spouse’s effective date of coverage could be as early as December 1st, because the SEP arose due to a marriage.

Example: A Rhode Islander loses their health insurance on October 31st. If this resident selects a plan and pays the current month’s premium (as well as any outstanding prior months’ premiums) during the 60-day SEP, the effective date of coverage can be November 1st, December 1st or January 1st.

F. 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.

In the event HSRI 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 their coverage, the customer will be responsible for paying for the requested coverage as long as the request is processed within 30 days of approval.

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.

Table 3.1 below provides a summary of the effective dates for enrollment, special enrollment, and the application of APTCs.

Table 3.1 - Summary of Effective Dates for Enrollment, Special Enrollment and Effective Dates for APTCs

Category	Coverage Effective Dates Details
Regular Enrollment in QHP	<p>A newly selected QHP is effective the first day of the next month if it is selected and payment is received by the 23rd day of the month, and the first day of the subsequent month if it is selected or paid for after the 23rd day of the month.</p> <p>For plans selected in the open enrollment period, typically November or December, payment must be received by the annual OEP deadline⁵² for an effective date of January 1st in the upcoming coverage year.</p>
APTC Effective Start Date	<p>The start date of APTCs will be the first of the month following the effective date of coverage for the following special enrollment scenarios:</p> <ul style="list-style-type: none"> • Birth • Adoption • Placement for adoption • Placement in foster care • Child support order/court order • Marriage • Loss of minimum essential coverage <p>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.</p>
APTC Effective End Date	<p>If eligibility changes and APTCs are discontinued, the effective end date for APTC discontinuance will generally be the last day of the month in which the eligibility determination is made. Please see Chapter 8, Section B.5.b for more information.</p>
Special Enrollment: Birth, Adoption, Foster Care, Court Order	<p>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.</p> <p>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.</p>
Special Enrollment: Marriage	<p>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 first 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.</p>
Special Enrollment: Loss of MEC	<p>When a new member reports loss of MEC, the new household member is eligible for coverage effective the first day of the month following the month in which the loss of MEC</p>

⁵²Again, the payment deadline is subject to change each annual Open Enrollment Period; see 220-RICR-90-00-1.6(C).

Category	Coverage Effective Dates Details
	occurred. ⁵³
Special Enrollment: American Indian	Special enrollment for QHPs is always open for American Indians from the first day of the month to the last day of the month. An American Indian/Alaskan Native (AI/AN) may enroll in a QHP or change QHPs up to one time per month.

G. **Automatic Renewal**

An eligible individual/family enrolled in a QHP will receive notice prior to open enrollment indicating whether the individual/family will be automatically renewed in the same or a similar plan during the subsequent annual OEP. 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. If the same plan is not available, customers will be renewed into the plan that most closely matches their current plan. Customers will not be automatically renewed into a plan that adds or removes coverage of comprehensive abortion services. Upon automatic renewal, coverage will be effective January 1st of the next year.

Customers are strongly encouraged to review plans during the annual OEP 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 HSRI, consumers will ensure that they are choosing the plan that is best suited to their needs.

Even though a customer may be automatically renewed, the customer 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 the customer 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.

H. **Guaranteed Availability Rule**⁵⁴

Beginning in plan year 2023, issuers may no longer deny coverage to an enrollee whose coverage was terminated in a previous year due to unpaid premiums.⁵⁵ Additionally, issuers cannot require an enrollee to pay any unpaid premiums from prior years to enroll in a new plan. However, if a person is currently enrolled in coverage during open enrollment or during an SEP, then payments may be applied toward any premiums currently due.

To apply a payment to an upcoming plan year rather than the current plan year, you must contact HSRI directly, either in-person or by phone, to terminate your current coverage, select a new plan, and make a binder payment to effectuate the new coverage. These requests must be made by December 31st or by the end of any applicable SEP. This will result in HSRI transferring any past-due balance from the prior year **to the issuer**. The issuer may still attempt to collect **any** outstanding premiums **owed**.

⁵³Refer to Section D(2)(a) of this Chapter for special situations where HSRI may allow for an alternative coverage start date due to loss of MEC.

⁵⁴45 CFR § 147.104(i); 87 FR 27208

⁵⁵ On August 22, 2025, a federal District Court judge stayed nationwide the implementation of several provisions of the Centers for Medicare & Medicaid Services (CMS) “Marketplace Integrity” final rule. A provision that would change the guaranteed availability rule as written here is now stayed pending litigation, and therefore this policy may change based on the outcome of *City of Columbus v. Kennedy*.

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 (PTCs) and cost-sharing reductions (CSRs) are subsidies made available by the federal government to help individuals and families pay for the cost of health insurance coverage purchased through HealthSource RI (HSRI). To be eligible for a PTC 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 HSRI; and
- Be without access to an affordable alternative source of coverage that meets basic standards, i.e., “minimum essential coverage” (MEC).

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

A PTC 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 HSRI.

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 refer to [Chapter 5](#).

HSRI 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.⁵⁶ HSRI will transmit individual eligibility and enrollment information to insurance 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, HSRI 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 contribution for coverage. The expected contribution is based on the federal poverty level (FPL) and uses on a sliding scale; it is indexed annually by federal regulation based on a range between 2% of income for households

⁵⁶ As required by 45 CFR § 155.340.

at 100% of the FPL to 9.5% of income for those at 400% of the FPL.

APTC eligible customers can use their APTCs to buy any category of health plan offered through HSRI. Their monthly payment may increase or decrease based on their plan selection.⁵⁷ After a customer enrolls in a plan and pays for the first month of coverage, the customer's health insurance carrier 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 HSRI except a Catastrophic plan.⁵⁸

2) Cost-Sharing Reductions

CSRs are available to households who earn 100% to 250% of the FPL⁵⁹ and enroll in a silver-level QHP plan through HSRI. CSRs are also available to American Indian and Alaska Native households who enroll in any level QHP (discussed further in Section D.4 of this chapter). 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, and eligibility for each depends on a household's income relative to 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:⁶⁰

- Meet other eligibility requirements to enroll in a QHP (see [Chapter 1](#));
- Lack access to other MEC, such as employer-based coverage, employer-based coverage through HSRI for Employers, Medicare, Medicaid, or CHIP (discussed further in [Section D.4](#) of this Chapter).
- Anticipate having an annual household income between 100%⁶¹ to 400% of the FPL;⁶²
- Plan to file a federal tax return and, if married, plan to file a joint return.⁶³ Married same-sex couples must also plan to file jointly;
- Cannot be claimed as a dependent on someone else's tax return;⁶⁴

⁵⁷ 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.

⁵⁸ 45 CFR § 156.440

⁵⁹ 45 CFR 155.305(g)

⁶⁰ 45 CFR § 155.305(f); 26 CFR § 1.36B-2

⁶¹ A previous exception allowing APTC for some lawfully present non-citizens under 100% FPL ended in Plan Year 2025. This exception previously allowed APTC if ineligible for Medicaid due to immigration status (sometimes known as the 5-year bar).

⁶² 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.

⁶³ 45 CFR § 155.300(a); 26 CFR § 1.36B-2(b)(2)

⁶⁴ 26 CFR § 1.36B-2(b)(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 taxpayer."

- Enroll in a QHP;⁶⁵

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.⁶⁶ For example, an individual 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 their spouse and children if the spouse and children meet eligibility requirements. If an individual is not applying for coverage for themselves, the individual must still provide the income and household information required to evaluate eligibility for other household members.

c. Special Rule for Victim of Domestic Abuse or Spousal Abandonment

If an individual is a victim of domestic abuse or spousal abandonment and is planning to file taxes married filing separately, this individual is eligible under this exception to receive APTC.⁶⁷

More information can be found here: <https://www.irs.gov/pub/irs-pdf/i8962.pdf>.

2) Household Composition and Size

To determine whether an applicant meets the financial eligibility criteria for an APTC, HSRI 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).⁶⁸ After the household is constructed, HSRI 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,⁶⁹ 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, HSRI will not provide any assistance or make a determination. HSRI 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.

⁶⁵ 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, the individual cannot receive an APTC for that month.

⁶⁶ 45 CFR § 155.305(f)

⁶⁷ 26 CFR § 1.36B-2

⁶⁸ 26 CFR § 1.36B-1(d)

⁶⁹ 45 CFR § 155.305(f)(ii); 26 CFR § 1.36B-2

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

Multiple-taxpayer households receiving separate APTCs may enroll together in one QHP.⁷⁰ For example, a 25-year-old expecting to file taxes separately from their parents may choose to enroll in the same QHP as their 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 100% of the FPL and 400% of the FPL⁷¹ Household income is also included in the calculation to determine the total amount of a household's APTC (see [Section C.2](#) of this Chapter).

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.⁷² 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*.⁷³

Example: Consider a married couple expecting to file federal taxes jointly who claim a personal exemption deduction for their 16-year-old child. The QHP household size is three; the two parents and a child. Both parents are employed and their child also earns \$300 per year through babysitting jobs. When determining their household income, the parents' income is included, but the child's income is not included because the child's earned income is below the tax filing threshold. The child is not required to file her own tax return. If, however, the child anticipates taking on an additional job that would pay enough money to put them over the tax-filing threshold, the child would be required to file their own tax form and their earnings would be included in the household's income.⁷⁴

b. Use of Projected Income

HSRI applies a household's "projected" annual income to assess its eligibility for APTCs.⁷⁵ 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 HSRI 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 HSRI for purposes of determining eligibility may either be

⁷⁰ 26 CFR § 1.36B-3(h)

⁷¹ 45 CFR § 155.305(f)(i); 26 CFR § 1.36B-2(b)

⁷² 45 CFR § 155.305(f); 26 CFR § 1.36B-1(e)

⁷³ IRS Publication 501 is available at: http://www.irs.gov/publications/p501/ar02.html#en_US_2012_publink1000220851.

⁷⁴ 26 CFR § 1.36B-1(e)(ii)(B)

⁷⁵ 45 CFR § 155.305(f)(i); 26 CFR § 1.36B-2(b)

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 resident loses their job in June and applies for coverage through HSRI on July 1st. To evaluate the individual’s eligibility for APTCs, HSRI needs to calculate their expected income for the entire year, because APTCs are calculated based on an annual income. To do this, HSRI will combine this resident’s earnings for the first half of the year while employed with any unemployment income this individual might have beginning in June for the rest of the year.

Note: If the Rhode Island resident earned \$20,000 during the first half of the year and expects to receive \$10,000 in unemployment benefits through December 31st, their projected annual income would be \$30,000 (\$20,000 for January through June plus \$10,000 for July through December). HSRI does NOT simply look at their 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, HSRI uses a measure of income known as “Modified Adjusted Gross Income” or “MAGI”.⁷⁶ 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 Internal Revenue Service (IRS):⁷⁷

- **Adjusted Gross Income**

Adjusted gross income is gross income adjusted by “above-the-line” deductions.⁷⁸ For most taxpayers, 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 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.⁷⁹ 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 taxpayers receive from bank accounts, money market

⁷⁶26CFR §1.36B-1(e)

⁷⁷26CFR §1.36B-1(e)(2)

⁷⁸26 USC § 62

⁷⁹26 CFR §1.36B-1(e)

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.⁸⁰

- **Foreign Earned Income**

While foreign earned income generally is not subject to taxation, it is included in MAGI.⁸¹ 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 the individual was:

- 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 twelve (12) consecutive months, is present in a foreign country for at least 330 full days during that period.

d. Determining MAGI

MAGI is rooted in the IRS definition of income developed to help taxpayers 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. HSRI will assist households in generating their projected annual MAGI based on their circumstances at the time of application. In practice, there are two ways HSRI can help applicants determine their household's projected annual MAGI: (1) use of prior year's federal tax return or (2) "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 HSRI to estimate based on the work that already has been done by the applicant to report their data and deductions in accordance with IRS rules. If the prior year's tax return is no longer relevant, HSRI 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.

- **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 have not changed notably since the applicant's last tax filling.

The adjusted gross income amount can be found at:⁸²

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

⁸⁰ 26 CFR § 1.36B-1(e); IRS-Income Received, available at: <http://www.irs.gov/taxtopics/tc403.html>.

⁸¹ 26 USC § 9

⁸² 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.

If applicable, HSRI 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), HSRI 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, HSRI will determine the household’s gross income. The types of income that count and do not count are identified in *Table 4.1* below.⁸³

Table 4.1 - Examples of What Income Counts & Does Not Count Under MAGI⁸⁴

Income that counts towards MAGI
Taxable wages/salary (before taxes are taken out) <i>Note: Pre-tax contributions to dependent care accounts, health insurance premiums, flexible spending accounts, retirement accounts and commuter expenses are NOT included income⁸⁵</i>
Self-employment (profit once business expenses are paid) ⁸⁶
Social Security benefits
Unemployment benefits
Certain 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

⁸³ 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>.

⁸⁴ 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.

⁸⁵ Czajka, John. May 2013. Translating Modified Adjusted Gross Income (MAGI) to Current Monthly Income. State Health Access Reform Evaluation. Available at: <https://collections.nlm.nih.gov/master/borndig/101613268/Translating%20Modified%20Adjusted%20Gross%20Income.pdf>

⁸⁶ 26 USC § 1402

Income that does NOT count towards MAGI
Child support received
Supplemental Security Income (SSI)
Worker's compensation payments
Veteran's benefits
Gifts
Temporary Disability Insurance (TDI)

e. 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.⁸⁷ Some of the tax deductions include:

- Certain self-employment business expenses
- Portion of interest on student loans
- Certain alimony paid
- Most contributions to retirement accounts⁸⁸
- Health savings account contributions⁸⁹
- Penalties on the early withdrawal of savings⁹⁰
- Educator expenses⁹¹
- Moving expenses related to a job change⁹²
- Certain business expenses of performing artists, reservists, and fee-basis government officials⁹³

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, and a portion of student loan interest.⁹⁴

f. 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,⁹⁵ self-employed SEP, SIMPLE, qualified plans,⁹⁶ and self-employed health insurance deductions.^{97,98}

⁸⁷ 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: <https://www.irs.gov/credits-deductions-for-individuals>.

⁸⁸ 26 USC § 219

⁸⁹ 26 USC § 223

⁹⁰ 26 USC § 165

⁹¹ 26 USC § 162

⁹² 26 USC § 217

⁹³ 26 USC § 162

⁹⁴ Credits and deductions for individuals: <https://www.irs.gov/credits-and-deductions-for-individuals>

⁹⁵ IRS Self-Employment Tax: <http://www.irs.gov/Businesses/Small-Businesses-&Self-Employed/Self-Employment-Tax-Social-Security-and-Medicare-Taxes>

⁹⁶ Id.

⁹⁷ 26 USC § 162

⁹⁸ For additional information see IRS Publication 334, Tax Guide for Small Business: <https://www.irs.gov/forms-pubs/about-publication-334>

g. Alimony Payment

Amounts paid to a spouse or a former spouse under a divorce or separation instrument (including a divorce decree, a separate maintenance decree, or a written separation agreement) may be alimony for federal tax purposes. Alimony is deductible by the payer spouse, and the recipient spouse must include it in income (subject to the note below).

Note: You cannot deduct alimony or separate maintenance payments made under a divorce or separation agreement (1) executed after 2018, or (2) executed before 2019 but later modified if the modification expressly states the repeal of the deduction for alimony payments applies to the modification. Alimony and separate maintenance payments you receive under such an agreement are not included in your income. *For more information, see IRS Topic No. 452 Alimony, available at: <https://www.irs.gov/taxtopics/tc452>.*

h. 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.⁹⁹ 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.

i. Comparing Household Income to the Federal Poverty Level

To assess financial eligibility for APTCs, HSRI will compare a household's projected annual income to the FPL guidelines for the appropriate household size.¹⁰⁰ HSRI will use the most recently published FPL guidelines available as of the first day of the annual OEP for coverage by a QHP offered through HSRI for a calendar year.^{101,102}

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](#)).¹⁰³

4) Ineligibility Based on Access to MEC

In general, people are ineligible for an APTC if they have sufficient income to secure adequate coverage (i.e., MEC) through a source other than HSRI.¹⁰⁴ 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 Eligibility¹⁰⁵

For purposes of APTC eligibility, the term “minimum essential coverage” or “MEC” means coverage under any of the following:

⁹⁹ 26 USC § 221; IRS-Student Loan Interest Deduction, available at: <http://www.irs.gov/taxtopics/tc456.html>.

¹⁰⁰ The FPL level is updated annually by the Secretary of Health and Human Services.

¹⁰¹ 45 CFR § 155.300(a)

¹⁰² 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 annual Open Enrollment Period will extend from October 1 through December 15.

¹⁰³ 42 CFR § 435.4

¹⁰⁴ 45 CFR § 155.305(f), 26 CFR § 1.36B-2(c)

¹⁰⁵ 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 10](#).

- Most government-sponsored insurance,
- Eligible employer-sponsored insurance,
- Grandfathered health plans,¹⁰⁶ 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:¹⁰⁷

- Accidental death and dismemberment coverage
- Disability insurance
- General liability insurance
- Automobile liability insurance
- Workers’ compensation
- Credit-only insurance (i.e., 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 (i.e., 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

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.¹⁰⁸ 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:¹⁰⁹

- Enrolled in Medicare Part A not requiring paying a Part A premium¹¹⁰ (most Medicare beneficiaries do not need to pay Part A premiums and are automatically considered eligible for MEC)

¹⁰⁶ 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)).

¹⁰⁷ 26 USC § 5000A(f)(3)

¹⁰⁸ 26 CFR § 1.36B-2(c)(2)(i)

¹⁰⁹ 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.

¹¹⁰ Proposed IRS Notice 2013-41, issued on June 26, 2013. Available at: <https://www.irs.gov/pub/irs-drop/n-13-41.pdf>.

- 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
- CHIP¹¹¹
- Enrolled in TRICARE
- Enrolled in Veteran’s health coverage (VA)¹¹²
- Peace Corps volunteer program
- Refugee medical assistance supported by the Administration for Children and Families
- Enrolled in a student health plan¹¹³
- Enrolled in State high risk pool coverage¹¹⁴

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 the individual may actually begin receiving benefits under the program.¹¹⁵ This means that an individual is **not** treated as eligible for a government-sponsored program (and therefore **is** eligible to receive APTC) 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 when this person can begin receiving benefits (i.e., the period of time between application approval and the effective date of coverage).

¹¹¹ Children ages 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.

¹¹² The veterans’ health coverage programs that represent MEC for those who are enrolled include the medical benefits package authorized for eligible veterans under 38 USC § 1710 and 38 USC § 1705; the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) authorized under 38 USC § 1781; comprehensive health care program authorized under 38 USC § 1803 and 38 USC § 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 USC § 1.5000A--2(b)(5) and (7)).

¹¹³ Proposed IRS Notice 2013-41, issued on June 26, 2013. Available at: <https://www.irs.gov/pub/irs-drop/n-13-41.pdf>.

¹¹⁴ 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: <https://www.irs.gov/pub/irs-drop/n-13-41.pdf>.

¹¹⁵ 26 CFR § 1.36B-2(c)(2)(i)

Example: Consider a taxpayer who applies for coverage under a government-sponsored health care program. The individual's application is approved on July 12th, but their coverage is not available until September 1st. The individual is considered eligible for government-sponsored MEC on September 1st¹¹⁶ and if meeting all other applicable criteria for APTC, would be considered APTC eligible through August 31st.

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 Veteran's 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.¹¹⁷ 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 life event (QLE).¹¹⁸

Example: Consider an individual who turns 65 years old on June 3rd and becomes eligible for Medicare. In compliance with requirements necessary to receive benefits, the individual enrolls in Medicare in September, the last month of their initial enrollment period, and is able to receive Medicare benefits beginning on December 1st. Because this individual completed necessary requirements by the last day of the third full calendar month after the event that established their eligibility (i.e., turning 65), the individual is treated as eligible for government-sponsored MEC on December 1st (the first full month this person may receive benefits under the program).¹¹⁹

Example: Consider the same scenario, except that the individual fails to enroll in the Medicare coverage during their 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 their eligibility).

iii. Special Rule for Veterans Coverage Programs

An individual is treated as eligible for MEC through a Veteran's health care program under *Chapter 17 or 18 of Title 38, USC*. only if the individual is actually enrolled in the program.¹²⁰

iv. Retroactive Eligibility

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 their 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

¹¹⁶ 26 CFR § 1.36 B-2(c)(2)(vi)

¹¹⁷ 26 CFR § 1.36B-2(c)(2)(ii)

¹¹⁸ 26 CFR § 1.36B-2(c)(2)(ii)

¹¹⁹ 26 CFR § 1.36B-2(c)(2)(vi)

¹²⁰ 26 CFR § 1.36B-2(c)(2)(iii)

the first day of the first calendar month beginning after the approval of the Medicaid application, as discussed above.¹²¹

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 their part-time employment and on April 10th applies for coverage under the Medicaid program. Their application is approved on May 15th, and their Medicaid coverage is effective as of April 1st. The individual is treated as eligible for government-sponsored MEC on June 1st.¹²²

v. Failure to Reconcile (FTR)

An enrollee shall not be eligible for APTCs if:¹²³

- (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 the Internal Revenue Code (26 USC §§ 6011, 6012)* and implementing regulations; **or**
- (2)** APTC was paid on behalf of the tax filer(s) for two prior consecutive years and was not reconciled for either of those two prior consecutive years.

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

After filing and reconciling APTCs for the applicable prior year(s), attesting to having filed a tax return on the application will allow an enrollee to maintain eligibility for APTC even if IRS' data has not yet been updated. Enrollees whose IRS data has not been updated but have filed a tax return and reconciled APTCs for the prior year(s), must attest to having filed and reconciled on the application and select a plan by December 31st to maintain APTC eligibility for January 1st coverage.

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”¹²⁴ **and**
- Provides “minimum value” (MV).¹²⁵

Employer-sponsored coverage includes coverage offered by a small business through HSRI for Employers. As described in more detail below, an eligible employer-sponsored plan is considered affordable for an individual if the annual premium the individual must pay to purchase coverage for themselves does not exceed a specified percentage of household income.¹²⁶ A plan is considered to provide MV only if the plan's share of the total allowed

¹²¹ 26CFR § 1.36B-2(c)(2)(iv)

¹²² 26 CFR § 1.36B-2(c)(2)(vi)

¹²³ 45 CFR § 155.305(f)(4); 26 USC § § 6011, 6012

¹²⁴ 26CFR § 1.36B-2(c)(3)(i)

¹²⁵ 26CFR § 1.36B-2(c)(3)(i)

¹²⁶ 26CFR § 1.36B-2(c)(3)(v)(A)

costs of benefits provided to the employee and related individuals is at least 60% of such costs.¹²⁷

i. Affordable Coverage

Beginning January 1, 2023, the definition of affordability for an eligible employer-sponsored plan has changed to include plans that cover all family members. (This change is sometimes referred to as fixing the “family glitch”.) An employer-sponsored plan is “affordable” if your share of the monthly premium in the lowest-cost plan offered by the employer is less than a certain percentage¹²⁸ of your household income.¹²⁹ The following conditions apply:

- The lowest-cost plan must also meet the MV standard.
- Total household income includes incomes from everybody in the household who’s required to file a tax return.
- For the employee, affordability is based on only the premium you’d pay for self-only (individual) coverage.
- For other members of the household (not the employee), affordability is based on the premium amount to cover everyone in the household.

When considering the above criteria, employer-sponsored coverage may be considered “affordable” for the employee only, for other household members but not the employee, for everyone in the household, or for no one in the household. Anyone in the household with access to affordable employer-sponsored coverage will not qualify for financial assistance in a QHP.

If employer coverage isn’t considered affordable for anyone, they may qualify for financial assistance in a QHP. If the premium is considered affordable for the employee, but not for other members of the household, then only the other household members may qualify for financial assistance, or vice versa. 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.

Example: Consider a woman who in 2026 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 2026 (which represents 7.3% of her household income). Because her required contribution for self-only coverage does not exceed 9.96% of household income, the plan is considered affordable, and the individual is treated as eligible for employer-sponsored MEC for all months in 2026.

Example: Consider the same scenario, except that in this case she is married with a child 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 her

¹²⁷ 26CFR § 1.36B-2(c)(3)(vi)

¹²⁸ Required Contribution Percentage for purposes of 26 U.S.C § 36B(c)(2)(C)(i)(II) and 26 C.F.R § 1.36B-2(c)(3)(v)(C) is 9.02% for 2025 and 9.96% for 2026.

¹²⁹ 26CFR § 1.36B-2(c)(3)(v)(A)

required contribution for **self-only coverage** does not exceed 9.96% of household income, she has affordable coverage through her employer’s self-only plan and is not eligible for financial assistance. Accordingly, the individual is determined to have a source of affordable employer-sponsored coverage, and thus ineligible to receive APTCs on behalf of herself. **However, because her family’s coverage through her employer is unaffordable according to the affordability test, her family is likely eligible for financial assistance through HSRI if they meet the other eligibility criteria.**

ii. **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 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).¹³⁰ See *Table 4.2* 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 their premiums is \$3,700. Another employee (Employee B) uses tobacco and the cost of their 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.¹³¹

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.¹³²

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 4.2* below.

¹³⁰ 26 CFR § 1.36B-2(c)(3)(v)(A)(4)

¹³¹ 26 CFR § 1.36B-2(c)(3)(v)(D)

¹³² 26 CFR § 1.36B-2(c)(3)(v)(A)(5)

Table 4.2 - 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.

iii. MV 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%.¹³³ 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 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.¹³⁴

Table 4.3 - Calculation of MV

<i>Minimum Value (MV) equals:</i>
$\frac{\text{Anticipated EHB Costs Reimbursed by Plan}}{\text{Anticipated EHB Costs Covered by "Standard" Self-Insured Plan}}$

Any one of the following methods can be used to determine whether an eligible employer-sponsored plan provides MV,¹³⁵ including use of:

- The MV Calculator made available by HHS and IRS on the HHS website;¹³⁶
- 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

¹³³ 26 CFR § 1.36B-2(c)(3)(vi)

¹³⁴ Proposed 26 CFR § 1.36B-6(c)(1)

¹³⁵ 26 CFR § 1.36B-6(d)

¹³⁶ The calculator is available at the following web site: <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/mv-calculator-final-4-11-2013.xlsm>.

level plan.¹³⁷

Note: 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.

iv. Safe Harbors for Determining MV¹³⁸

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 4.4* below.

Table 4.4 - Safe Harbors for Determining MV

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	N/A	N/A
\$6,400	\$4,500 integrated medical and drug		70% of all	N/A	\$500
\$6,400	\$3,500	\$0	60% medical 75% drug	\$10/\$20/\$50 Specialty drugs at 75%	N/A

v. Treatment of Wellness Incentives and Employer Contributions to HRAs and 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 4.1](#) for details on related requirements.

vi. Treatment of Open Enrollment Periods (OEPs) and Special Enrollment Periods (SEPs)

As with government programs, people are excluded from APTC eligibility if they could

¹³⁷ 26 CFR § 1.36B-6(d)(4)

¹³⁸ 26 CFR § 1.36B-6(d)

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 OEP or SEP¹³⁹ (see [Chapter 3](#) for information on SEPs). 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.¹⁴⁰

Example: Consider an individual whose employer offers its employees a health insurance plan that has a plan year from October 1st through September 30th. Employees may enroll during an open season from August 1st to September 15th. In this scenario, the employee chooses not to enroll in the employer’s plan for the October 1, 2023 – September 30, 2024, plan year, and in November 2023, the employee enrolls in a QHP through HSRI for calendar year 2024. Because the employee could have enrolled in the employer’s plan during the August 1st to September 15th open enrollment period, unless the plan is not affordable or does not provide MV, this individual is treated as eligible for employer-sponsored MEC for those months that the employee is enrolled in the QHP during the employer’s plan year (i.e., from January through September 2024).¹⁴¹

vii. Continuation Coverage (i.e., COBRA)

An individual who may enroll in continuation coverage required under federal (i.e., 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.¹⁴² If someone is provided with an offer to sign up for COBRA coverage, but opts not to do so, this does not adversely affect their potential eligibility for an APTC.

viii. 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.¹⁴³ 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 this employee 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.¹⁴⁴

¹³⁹ 26 CFR § 1.36B-2(c)(3)(iii)

¹⁴⁰ 26 CFR § 1.36B-2(c)(3)(iii)

¹⁴¹ 26 CFR § 1.36B-2(c)(3)(iii)(C)

¹⁴² 26 CFR § 1.36B-2(c)(3)(iv)

¹⁴³ 26 CFR § 1.36B-2(c)(3)(vii)(A)

¹⁴⁴ 26 CFR § 1.36B-2(c)(3)(vii)(B)

Example: Consider an individual whose required contribution for self-only employer coverage exceeded 9.02% of their 2025 projected annual household income. The individual enrolls in their employer’s calendar year plan for 2025. The individual was treated as eligible for MEC for 2025 because the individual was enrolled in an eligible employer-sponsored plan for 2025.¹⁴⁵

Example: Consider the same scenario, except that now the individual’s employer automatically enrolled this individual in the plan for calendar year 2026. The individual terminates this coverage on January 20, 2026. The individual is treated as not eligible for MEC under their employer’s plan for January 2026.¹⁴⁶

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 (i.e., 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 this individual 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, the related individual 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 adult child. If the parents expect to claim a personal exemption deduction for the 25-year-old, the adult child is treated as eligible for MEC through the parent’s employer-sponsored coverage (assuming it is affordable and meets MV). However, if the parents do not expect to claim a personal exemption for the adult child, the child would be treated as eligible for employer-sponsored MEC only for any months during which they are actually enrolled in their parents’ plan. Thus, if the child chooses to purchase coverage on their own via HSRI, the child is potentially eligible for an APTC (i.e., the child is not excluded based on having MEC through their parents, but must still meet the other eligibility criteria for an APTC).

C. Calculation of APTC

1) Overview of APTC Calculation

The concept behind the APTC calculation is that households below 400% of the 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% of the FPL to 9.5% of income for those at 400% of the FPL.¹⁴⁷ 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 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 their 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

¹⁴⁵ 26 CFR § 1.36B-2(c)(3)(vii)(C)

¹⁴⁶ 26 CFR § 1.36B-2(c)(3)(vii)(C)

¹⁴⁷ ACA Sec. 1401/Sec. 36B (b); 26 CFR § 1.36B-3(g)

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 [Section C.4](#) 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").¹⁴⁸ 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 a QHP

When an individual files taxes, the IRS reconciles the amount of APTC that the person received with the amount this individual is eligible to receive based on their tax return information.¹⁴⁹

Please see [Chapter 5](#) for further discussion about 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 HSRI that can be used to cover the household members who are enrolling in a QHP.¹⁵⁰ In situations where some household members are enrolling in a QHP through HSRI 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 a projected annual household income of 210% of the FPL. The children are eligible for Medicaid and the parents are eligible for a QHP and APTCs on HSRI. 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 Members¹⁵¹

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 HSRI Contact Center.

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

¹⁴⁸ 26CFR §1.36B-3(d)

¹⁴⁹ 26CFR §1.36B-4

¹⁵⁰ 26CFR §1.36B-3(e)

¹⁵¹ 26CFR §1.36B-3(f)(ii)(2)

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 Affordable Care Act (ACA).¹⁵²

Table 4.5 - Premium Contribution Applicable Percentage by Income (adjusted annually)¹⁵³

% of Federal Poverty Line	Premium Contribution Initial	Premium Contribution Final Percentage
Less than 133%	2.0%	2.0%
133-150%	3.0%	4.0%
150-200%	4.0%	6.3%
200-250%	6.3%	8.05%
250-300%	8.05%	9.5%
300-400%	9.5%	9.5%

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.¹⁵⁴ In effect, the adjustments lower the expected contribution of such households because not all their members can be enrolled in a QHP.

d. Actual Premium Costs

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.¹⁵⁵ QHPs may have a non-essential health benefit (non-EHB) portion of the premium that is not eligible for a PTC. In other words, the APTC cannot be used to cover certain health benefits that do not fall within the ACA’s definition of “Essential Health Benefit” (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 EHBs. 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

¹⁵² 26CFR §1.36B-3(g)

¹⁵³ Note that applicable percentages in the table may be adjusted for taxable years beginning after December 31, 2018, to reflect rates of premium growth relative to growth in the consumer price index.

¹⁵⁴ 26CFR §1.36B-2; 26CFR §1.36B-3

¹⁵⁵ 26CFR §1.36B(3)

child count toward the actual premiums paid.¹⁵⁶

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.¹⁵⁷

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

4) **Treatment of Non-EHBs**

As mentioned earlier in this chapter, APTCs are available only to support the cost of purchasing EHBs.¹⁵⁸ APTCs may not be used to subsidize the cost of optional benefits, including elective abortions.¹⁵⁹ 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-EHBs, 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-EHBs. When assessing whether the household's APTC exceeds actual premium costs, HSRI would treat the household as having only \$14,000 in actual premium costs. Similarly, when identifying the applicable benchmark plan, HSRI would take into account only the cost of the EHBs 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

¹⁵⁶ 26CFR §1.36B-3(c)(2)

¹⁵⁷ 26CFR §1.36B-3(h)

¹⁵⁸ 26CFR §1.36B-3(j)

¹⁵⁹ 42 U.S.C § 18023; 45 CFR § 156.280

APTCs.¹⁶⁰ 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 SLCSF available on HSRI, 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 HSRI 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 the “excess” APTCs toward the cost of the dental plan.

Example: Consider a single parent with two kids who purchases a QHP that costs \$400 a month and a stand-alone dental plan for both of the children that costs a total of \$50 a month. When evaluating the cost of the applicable benchmark plan for the family (and, thus, the size of their tax credit), HSRI cannot take into account the cost of the children’s dental coverage. If, however, the parent 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 SLCSF that includes pediatric dental benefits.

D. Cost-Sharing Reduction Levels

Households with a projected annual income of up to 250% of the FPL - with exceptions for American Indian and Alaska Native (AI/AN) applicants - are eligible for CSRs that reduce out-of-pocket spending.¹⁶¹ 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 QHP¹⁶² (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” (“AV”). The AV 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 policies. As shown in *Table 4.6* below, there are three major tiers of CSRs.

Table 4.6 - Tiers of CSRs Available to Households Enrolling in a Silver-Level Plan

Tier	Population	Silver-Level Plan Actuarial
Tier 1	100% – 150% FPL	94%
Tier 2	150% – 200% FPL	87%
Tier 3	200% – 250% FPL	73%

In addition, as discussed in more detail below, AI/AN applicants are eligible for special CSRs.¹⁶³ AI/AN

¹⁶⁰ 26 CFR § 1.36B-3(k)

¹⁶¹ 45 CFR § 155.305(g)(C)

¹⁶² 45 CFR § 155.305(g)(C)(ii)

¹⁶³ 45 CFR § 155.350

applicants under 300% of the FPL receive 100% CSR for any level QHP in which they enroll.¹⁶⁴

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

- Silver-level plan QHP 100%-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. HSRI assigns applicants to one of the silver-level QHP variations based on income, subject to the special rule on family policies.¹⁶⁵

1) Eligibility Criteria for CSRs

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:¹⁶⁶

- Meet the eligibility criteria for an APTC, including QHP requirements¹⁶⁷ (see [Chapter 2](#));
- Anticipate having annual household income at or below 250% of the FPL¹⁶⁸ (with exceptions for AI/AN applicants); and
- Enroll in a silver-level QHP (with exceptions for AI/AN applicants).¹⁶⁹

CSRs are not available for Catastrophic plans or stand-alone pediatric dental plans.¹⁷⁰

Example: Consider a household of two parents and two children with projected annual household income of 210% of the 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% of the 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 are not eligible for a CSR because they are not in a silver-level QHP.

2) Changes in Eligibility for CSRs

If HSRI 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 CFR § 156.410(b)* as of the effective date of eligibility required by HSRI.¹⁷¹

In the case of assignment to a new silver plan (or standard plan without CSRs) of the same QHP

¹⁶⁴ 45 CFR § 155.350(a)(2)

¹⁶⁵ 45 CFR § 156.410(b)(1)

¹⁶⁶ 45 CFR § 305(g)

¹⁶⁷ 45 CFR § 155.305(g)(A)

¹⁶⁸ 45 CFR § 305(g)(C)

¹⁶⁹ 45 CFR § 155.305(g)(C)(ii)

¹⁷⁰ 45 CFR § 156.440

¹⁷¹ 45 CFR § 156.425(a)

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 CSRs) applicable to that coverage year is taken into account in the new plan (or standard plan without CSRs) 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.¹⁷² Meaning, if eligibility for CSR 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 ten (10) 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 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.¹⁷³

Example: Consider a couple with projected annual household income of 260% of the FPL in which one individual is a tribal member while the other is not. If the couple purchases a QHP together, they would not be eligible for any CSRs because one spouse 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.¹⁷⁴ 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 American Indians.¹⁷⁵ Information about verifying AI/AN status can be found in [Chapter 7](#).

a. No Cost-Sharing Obligation for AI/AN below 300% of the FPL

AI/AN applicants who enroll in a QHP, are eligible for an APTC, and have projected annual household income below 300% of the FPL may enroll in a QHP with no cost-sharing obligations (known as a “zero cost-sharing plan”).¹⁷⁶ 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

¹⁷² 45 CFR § 156.425(b)

¹⁷³ 45 CFR § 155.305(g)(3)

¹⁷⁴ 45 CFR §155.155.350; 45 CFR §156.410(b)(2)-(3)

¹⁷⁵ 25 USC § 450(b)

¹⁷⁶ 45 CFR § 155.350(a)(ii)

level QHP and have no cost-sharing obligations.¹⁷⁷

b. Limited Cost-Sharing Obligation for All Other AI/AN

All other AI/AN QHP applicants (i.e., those above 300% 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.¹⁷⁸ 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.¹⁷⁹ If a non-AI/AN household member is determined ineligible for cost-sharing reductions and chooses to enroll in a QHP, then that individual will be enrolled into that QHP with no cost-sharing reductions.¹⁸⁰

Example: An AI/AN household with projected annual household income of 200% of the 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% of the 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 4.1 - Treatment of Wellness Incentives and Employer Contributions to HRAs and 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).¹⁸¹

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 their premiums is \$3,700. Another employee (Employee B) uses tobacco and the cost of their 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

¹⁷⁷ 45 CFR § 155.350(a)(ii)(2)

¹⁷⁸ 45 CFR § 156.410(b)(3)

¹⁷⁹ 45 CFR § 155.350(b); 45 CFR §156.410(b)(2)

¹⁸⁰ 45 CFR § 156.410(b)(4)

¹⁸¹ 26 CFR § 1.36B-6(c)(2)(i)

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.

All employer contributions for the current plan year to an HSA will be taken into account in that plan year towards 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).¹⁸² 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).¹⁸³

Table A-4.1 - 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 can be used only for reduced cost-sharing.

2) Appendix 4.2 - 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.

¹⁸² 26 CFR § 1.36B-6(c)(3)

¹⁸³ 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 (HSRI).¹⁸⁴ Tax credits are subsidies provided by the federal government directly to health insurance companies to help individuals and families pay for QHP premiums. Though HSRI determines eligibility for APTCs, HSRI does not administer federal tax credits directly, nor does HSRI 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.¹⁸⁵ 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 their income.

This reconciliation is required by law¹⁸⁶ 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 their 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 their 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 HSRI 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 HSRI 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

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

- **Advance Premium Tax Credits (APTCs):** *Customers receive these tax credits in advance when they purchase 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

¹⁸⁴ 26 CFR § 1.36B-2(a)

¹⁸⁵ 26 CFR § 1.36B-4(a)(1)(i)-(ii)

¹⁸⁶ 26 CFR § 1.36B-4(a)(i)

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.¹⁸⁷

- **Premium Tax Credit (PTC):** 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 some of their PTC 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: An individual applies for health coverage and estimates that their annual income will be 200% of the Federal Poverty Level (FPL). HSRI finds them eligible for \$3,752.00 in tax credits.¹⁸⁸

This individual 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.

When an individual’s actual annual income at tax filing time is different than the person anticipated, the size of their premium tax credit will be adjusted accordingly. If this individual chooses to receive all or some of their anticipated credit in advance, their tax return will be subject to reconciliation, meaning this individual will pay back some of the tax credit paid out on their behalf.

1) Reconciling APTCs at End of Year

Taxpayers must reconcile all PTCs they receive in advance, including credits they receive on behalf of members of their family.¹⁸⁹ The final PTC amount is calculated based on actual income reported when individuals file their federal income taxes.¹⁹⁰ The IRS compares the amount of APTCs the individuals received to the PTC they are eligible for based on their actual income as reported on their federal income taxes.

¹⁸⁷ 45 CFR § 155.310(d)(2)

¹⁸⁸ All examples in this chapter are used for illustrative purposes only. Numbers may not add due to rounding. All examples use a benchmark premium of \$5,200.

¹⁸⁹ See generally 26 CFR §1.36B-4.

¹⁹⁰ 26 CFR § 1.36B-4(2)

If APTCs received during the year are less than the amount of the PTC 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 APTC for the year is more than the amount of the PTC for which an individual qualifies when taxes are filed, the individual must repay the excess advance payments with their tax return filing.

Example: Person A applies for health coverage and estimates that their annual income will be \$35,000. Person A is eligible for a PTC in the amount of \$2,000. Person A chooses to receive all the \$2,000 PTC in advance (\$166.66 each month) and it reduces the amount they must pay in monthly premiums. At the end of the year when Person A files federal income taxes, their actual annual income is \$28,000. Based on their actual annual income, Person A is eligible for a \$2,500 tax credit. Because the PTC Person A received in advance was \$2,000 and they actually qualify for a \$2,500 tax credit, Person A will receive a tax refund of \$500 when they file their federal income taxes.

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

a. Reconciliation Process & Applicable IRS Forms

HSRI will mail *IRS Form 1095-A, Health Insurance Marketplace Statement* to all customers in early February of the following year.¹⁹¹ Once the form is mailed, HSRI will also post a 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 PTC), must file a *Form 8962, Premium Tax Credit (PTC)*, and attach it to their federal income tax return for that year.¹⁹²

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 HSRI 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 (such as 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 HSRI without a tax credit (meaning they paid the full

¹⁹¹ See Chapter 5 Appendix for a sample IRS Form 1095-A.

¹⁹² See Chapter 5 Appendix for a sample IRS Form 8962.

monthly premium), they may use *Form 8962* to determine if they are eligible for a tax credit when they submit their tax filing.

i. **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 HSRI 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 HSRI.

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:

- The monthly premium amount of the health plan the customer selected,
- The premium amount of the Second Lowest Cost Silver Plan (SLCSP) available on the exchange, and
- The advance payment of the PTC paid on the customer’s behalf to the health insurance company that offers their plan

If a customer or member of their 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*.

Note: *Form 1095-A* will **ONLY** be sent to the person identified as the tax filer. HSRI will not send the form to anyone except the tax filer.

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

ii. **Tax Repayment Capped through Tax Year 2025 for Individuals with Actual Income Less Than 400% of FPL**

Individuals who receive an APTC that is more than the amount of the PTC for which they qualify at the end of the year must repay the excess when they file taxes. However, for taxable years beginning after December 31, 2014, and continuing through December 31, 2025, individuals with a household income below 400% of the FPL have their repayment capped based on their income, as determined by the IRS.¹⁹³

Starting with tax year 2026, the repayment cap for individuals with household income below 400% of the FPL has been eliminated, and all excess APTCs must be re-paid.¹⁹⁴

Additional information is available at: <https://www.irs.gov/affordable-care->

¹⁹³ 26 CFR § 1.36B-4(a)(3)

¹⁹⁴ 26 USC § 36B(f)(2); Pub. L. 119–21, Title VII, §71305, July 4, 2025, 139 Stat. 324-325

[act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit.](#)

iii. No Cap on Repayment Obligations for Individuals with Actual Income Above 400% of FPL

Individuals with taxable income above 400% of the FPL are not eligible for a PTC. If individuals receive APTCs based on an estimate that their income will be below 400% of the FPL, they must return all APTCs they received during the year if their actual year-end taxable income is above 400% of the FPL. There is no cap on the repayment obligation for individuals and families in this income bracket.¹⁹⁵ Please see *IRS Publication 974, Premium Tax Credit (PTC)* for additional information.

Example: When Person A applies for coverage, they anticipate having an annual household income of 250% of the FPL. Person A receives an APTC in the amount of \$2,888 (\$241 per month). At the end of the year when Person A files their federal income taxes, their household income is 410% of the FPL. Person A must pay back the \$2,888 when they file their federal income taxes at the end of the year.

iv. Rule for Individuals with Annual Household Income Below 100% of the FPL at End of Year

Individuals with income below 100% of the FPL are not eligible for APTC (see [Chapter 4](#)).¹⁹⁶ However, if an individual anticipates that their annual income will qualify the individual for APTC, 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 PTC and, for reconciliation purposes, the amount of tax credit is calculated based on actual income as reflected on the tax return.¹⁹⁷ However, individuals may not keep the PTC if they, with intentional or reckless disregard for the facts, provided incorrect information to HSRI. Please see *IRS Publication 974, Premium Tax Credit (PTC)* for additional information.

Example: When Person A applies for coverage, they anticipate having annual household income of 150% of the FPL. Person A is eligible for a PTC in the amount of \$4,511 (\$376 per month) and chooses to receive it all in advance. At the end of the year when Person A files federal income taxes, their household income is 90% of the FPL. Since Person A's household income is below 100% of the FPL, they are not required to pay back the PTC they received in advance.

v. 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 monthly premiums in full are given a three-month grace period.¹⁹⁸ 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

¹⁹⁵ 26 CFR § 1.36B-4(a)(3)(ii)

¹⁹⁶ 26 CFR § 1.36B-2(b)(6)

¹⁹⁷ 26 CFR § 1.36B-2(b)(7)

¹⁹⁸ 26 CFR § 1.36B-4(a)(iii); 45 CFR § 156.270 (d)

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 HSRI any changes that may impact APTC eligibility that occur during the year, such as changes in income, family size, access to Minimum Essential Coverage (MEC), or tax filing status. Changes must be reported within thirty (30) days of when they occur.¹⁹⁹ When HSRI 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, HSRI reduces the risk that customers will face a repayment obligation at the end of the tax year.²⁰⁰ When taxpayers marry or divorce, they face some special reconciliation rules, described later in this section.

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

When an individual applies for health coverage, this individual provides information on the amount of income the person's household anticipates it will earn for the entire year. During the course of the year, a household's income or size may increase (i.e., due to a new job, drop in household size when a child leaves home), or decrease (i.e., due to loss of a job, or increase in household size after a birth). When such changes occur, HSRI must recalculate income and adjust a household's APTCs.²⁰¹ 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 HSRI 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 MEC.

2) HSRI Data Quality Assurance

HSRI 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, the customer will receive updated notice(s) informing them of any change in eligibility or plan cost which may have occurred. If an individual does not receive *Form 1095-A* or has questions regarding information on *Form 1095-A*, they can contact HSRI. Requests to review any *1095-A* discrepancies should be made at least thirty (30) days prior to the IRS tax filing deadline so that HSRI can provide an updated *Form 1095-A* in advance of the tax filing

¹⁹⁹ 45 CFR § 155.330(b)

²⁰⁰ 45 CFR § 155.330(g)

²⁰¹ 45 CFR § 155.330(e)(1)

deadline. 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, 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 PTC for reconciliation purposes, if the alternative computation works to their benefit.²⁰² Please see *IRS Publication 974, Premium Tax Credit (PTC)* 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.²⁰³ 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 PTCs). Please see *IRS publication 974, Premium Tax Credit (PTC)* for additional information.

²⁰² 26 CFR § 1.36B-4(b)(2)

²⁰³ 26 CFR § 1.36B-4(b)(3)

D. Appendix
1) Appendix 5.1 - Sample IRS Form 1095-A

Form 1095-A	Health Insurance Marketplace Statement	<input type="checkbox"/> VOID	OMB No. 1545-2232
Department of the Treasury Internal Revenue Service	Do not attach to your tax return. Keep for your records. Go to www.irs.gov/Form1095A for instructions and the latest information.	<input type="checkbox"/> CORRECTED	2025

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 Covered Individuals				
A. Covered individual name	B. Covered individual SSN	C. Covered individual date of birth	D. Coverage start date	E. Coverage termination date
16				
17				
18				
19				
20				

Part III Coverage Information			
Month	A. Monthly enrollment premiums	B. Monthly second lowest cost silver plan (SLCSP) premium	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** (2025) Created 6/5/25

2) Appendix 5.2 - Sample IRS Form 8962

Form 8962 Department of the Treasury Internal Revenue Service	Premium Tax Credit (PTC) Attach to Form 1040, 1040-SR, or 1040-NR. Go to www.irs.gov/Form8962 for instructions and the latest information.	OMB No. 1545-0074 2024 Attachment Sequence No. 73				
Name shown on your return		Your social security number				
A. You cannot take the PTC if your filing status is married filing separately unless you qualify for an exception. See instructions. If you qualify, check the box <input type="checkbox"/>						
Part I Annual and Monthly Contribution Amount						
1 Tax family size. Enter your tax family size. See instructions		1				
2a Modified AGI. Enter your modified AGI. See instructions	2a					
b Enter the total of your dependents' modified AGI. See instructions	2b					
3 Household income. Add the amounts on lines 2a and 2b. See instructions		3				
4 Federal poverty line. Enter the federal poverty line amount from Table 1-1, 1-2, or 1-3. See instructions. Check the appropriate box for the federal poverty table used. a <input type="checkbox"/> Alaska b <input type="checkbox"/> Hawai'i c <input type="checkbox"/> Other 48 states and DC		4				
5 Household income as a percentage of federal poverty line (see instructions)		5 %				
6 Reserved for future use						
7 Applicable figure. Using your line 5 percentage, locate your "applicable figure" on the table in the instructions		7				
8a Annual contribution amount. Multiply line 3 by line 7. Round to nearest whole dollar amount	8a	8b Monthly contribution amount. Divide line 8a by 12. Round to nearest whole dollar amount				
Part II Premium Tax Credit Claim and Reconciliation of Advance Payment of Premium Tax Credit						
9 Are you allocating policy amounts with another taxpayer or do you want to use the alternative calculation for year of marriage? See instructions. <input type="checkbox"/> Yes. Skip to Part IV, Allocation of Policy Amounts, or Part V, Alternative Calculation for Year of Marriage. <input type="checkbox"/> No. Continue to line 10.						
10 See the instructions to determine if you can use line 11 or must complete lines 12 through 23. <input type="checkbox"/> Yes. Continue to line 11. Compute your annual PTC. Then skip lines 12-23 <input type="checkbox"/> No. Continue to lines 12-23. Compute your monthly PTC and continue to line 24.						
Annual Calculation	(a) Annual enrollment premiums (Form(s) 1095-A, line 33A)	(b) Annual applicable SLCSP premium (Form(s) 1095-A, line 33B)	(c) Annual contribution amount (line 8a)	(d) Annual maximum premium assistance (subtract (c) from (b); if zero or less, enter -0-)	(e) Annual PTC 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 enrollment premiums (Form(s) 1095-A, lines 21-32, column A)	(b) Monthly applicable SLCSP premium (Form(s) 1095-A, lines 21-32, column B)	(c) Monthly contribution amount (amount from line 8b or alternative marriage monthly calculation)	(d) Monthly maximum premium assistance (subtract (c) from (b); if zero or less, enter -0-)	(e) Monthly PTC 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 PTC. Enter the amount from line 11(e) or add lines 12(e) through 23(e) and enter the total here					24	
25 Advance payment of PTC. Enter the amount from line 11(f) or add lines 12(f) through 23(f) and enter the total here					25	
26 Net PTC. If line 24 is greater than line 25, subtract line 25 from line 24. Enter the difference here and on Schedule 3 (Form 1040), line 9. If line 24 equals line 25, enter -0-. Stop here. If line 25 is greater than line 24, leave this line blank and continue to line 27					26	
Part III 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 (see instructions)					28	
29 Excess advance PTC repayment. Enter the smaller of line 27 or line 28 here and on Schedule 2 (Form 1040), line 1a					29	

For Paperwork Reduction Act Notice, see your tax return instructions.

Cat. No. 37784Z

 Form **8962** (2024)

2) Appendix 5.2 - Sample IRS Form 8962 (ctd.)

Form 8962 (2024)

 Page **2**

Part IV Allocation of Policy Amounts

Complete the following information for up to four policy amount allocations. See instructions for allocation details.

Allocation 1

30	(a) Policy Number (Form 1095-A, line 2)	(b) SSN of other taxpayer	(c) Allocation start month	(d) Allocation stop month
	Allocation percentage applied to monthly amounts	(e) Premium Percentage	(f) SLCSP Percentage	(g) Advance Payment of the PTC Percentage

Allocation 2

31	(a) Policy Number (Form 1095-A, line 2)	(b) SSN of other taxpayer	(c) Allocation start month	(d) Allocation stop month
	Allocation percentage applied to monthly amounts	(e) Premium Percentage	(f) SLCSP Percentage	(g) Advance Payment of the PTC Percentage

Allocation 3

32	(a) Policy Number (Form 1095-A, line 2)	(b) SSN of other taxpayer	(c) Allocation start month	(d) Allocation stop month
	Allocation percentage applied to monthly amounts	(e) Premium Percentage	(f) SLCSP Percentage	(g) Advance Payment of the PTC Percentage

Allocation 4

33	(a) Policy Number (Form 1095-A, line 2)	(b) SSN of other taxpayer	(c) Allocation start month	(d) Allocation stop month
	Allocation percentage applied to monthly amounts	(e) Premium Percentage	(f) SLCSP Percentage	(g) Advance Payment of the PTC Percentage

34 Have you completed all policy amount allocations?

- Yes.** Multiply the amounts on Form 1095-A by the allocation percentages entered by policy. Add all allocated policy amounts and non-allocated policy amounts from Forms 1095-A, if any, to compute a combined total for each month. Enter the combined total for each month on lines 12-23, columns (a), (b), and (f). Compute the amounts for lines 12-23, columns (c)-(e), and continue to line 24.
- No.** See the instructions to report additional policy amount allocations.

Part V Alternative Calculation for Year of Marriage

Complete line(s) 35 and/or 36 to elect the alternative calculation for year of marriage. For eligibility to make the election, see the instructions for line 9. To complete line(s) 35 and/or 36 and compute the amounts for lines 12-23, see the instructions for this Part V.

35	Alternative entries for your SSN	(a) Alternative family size	(b) Alternative monthly contribution amount	(c) Alternative start month	(d) Alternative stop month
36	Alternative entries for your spouse's SSN	(a) Alternative family size	(b) Alternative monthly contribution amount	(c) Alternative start month	(d) Alternative stop month

 Form **8962** (2024)

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 & Regulations²⁰⁴ for the most accurate information regarding Medicaid eligibility Rules.

Note: Medicaid eligibility rules are set by the Executive Office of Health & Human Services (EOHHS), not by HealthSource RI (HSRI). HSRI 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.²⁰⁵ 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 general eligibility,²⁰⁶ cooperation,²⁰⁷ characteristic,²⁰⁸ and financial requirements.²⁰⁹ Please refer to the most up-to-date version of the Medicaid Rules & Regulations for more information regarding Medicaid eligibility requirements.

HSRI adheres to a “No Wrong Door” policy, ensuring that any eligible Rhode Island resident may contact HSRI 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 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;
 - Are not entitled to or enrolled in Medicare Part A or B benefits;

²⁰⁴ Available at <http://www.eohhs.ri.gov/>.

²⁰⁵ For an overview of government-sponsored health insurance care available in Rhode Island, please see 210-RICR-30-00-1.

²⁰⁶ 210-RICR-30-00-1.6

²⁰⁷ 210-RICR-30-00-1.8

²⁰⁸ 210-RICR-30-00-1.5(A)(1)

²⁰⁹ 210-RICR-30-00-5

- Are not otherwise eligible for and enrolled in another coverage group; and
- Have household income that is at or below 133% of the federal poverty level (FPL).^{210,211}

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 their household.²¹² 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 Advance Premium Tax Credit (APTC) and cost-sharing reduction (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 this individual is living. In contrast, each person who is part of a taxpayer household for APTC and CSR eligibility purposes is considered to have the same household and the same household income.²¹³ 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

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 Internal Revenue Service (IRS)-based measure of income known as “Modified Adjusted Gross Income”²¹⁴ with some modifications.²¹⁵ That said, there is a substantial difference when evaluating income for Medicaid versus eligibility for APTCs and CSRs. While HSRI determines APTC and CSR eligibility using estimated annual income, EOHHS uses current monthly income to determine eligibility for Medicaid.²¹⁶ 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.

D. HSRI Auto-Enrollment Program

Individuals who are terminated from Medicaid, are eligible for APTCs, and have an annual household income at less than 200% of the FPL may be automatically enrolled into a designated medical plan

²¹⁰ Under federal law, adults covered under 42 CFR § 435.119 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 § 435.119 will be limited, as a practical matter, to adults without dependent children.

²¹¹ 210-RICR-30-00-1.5(A)(1)(f); 42 CFR § 435.119

²¹² 42 CFR § 435.603(f)

²¹³ 42 CFR § 435.603(f)

²¹⁴ 42 CFR § 435.603(e)

²¹⁵ 42 CFR § 435.603(e)

²¹⁶ 42 CFR § 435.603(h)

through HSRI with the option to change their plan, add dental coverage, or opt out of coverage during their 60-day SEP.²¹⁷ Individuals who are automatically enrolled under this section must pay their health insurance premium by the end of the 60-day SEP in order to bind and effectuate coverage or their enrollment will be cancelled.

Visit <https://www.healthsourceri.com/transitions/> for more information.

²¹⁷ Rhode Island Public Laws, Ch. 117, Art. 9, § 5 (2024); 220-RICR-90-00-1.8(D)

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 (QHP), 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 (HSRI), 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 ("ID Proofing") is the process of confirming an applicant's identity. HSRI verifies an applicant's identity using a service provided by Experian. Experian helps HSRI 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 [Section F](#) of this Chapter.

b. **Who is required to complete ID Proofing?**

ID Proofing is required for the primary account contact who is applying for coverage for themselves and/or on behalf of their 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, the customer must log into an online account and complete ID Proofing before the customer can access an online application. Individuals can complete ID Proofing online or use assistance from the HSRI Contact Center. Certified Application Counselors (CACs) 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 HSRI Contact Center for manual ID Proofing or come to the HSRI Contact Center with identification.

3) Database Verification

HSRI will attempt to verify an applicant's personal information (such as income, Social Security Number (SSN), citizenship and immigration status) against a variety of state and federal data sources when available.²¹⁸ For more information, please refer to HSRI's application policies on www.HealthSourceRI.com.

In most cases, an applicant will need to provide personal information for HSRI to determine the applicant's eligibility for health coverage and financial help. If this personal information cannot be verified, HSRI 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.²¹⁹

HSRI performs a monthly check for accounts that have failed to provide the necessary documentation by the due date. If those documents are not provided in timely fashion, **HSRI may 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"²²⁰ as determined by the Affordable Care Act (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 HSRI 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 applies, 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 thirty (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.

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 cost-sharing reduction (CSR) plan to a non-CSR plan.

²¹⁸ 45 CFR § 155.315

²¹⁹ 45 CFR § 155.315(f)(4)(1)

²²⁰ 45 CFR § 155.320(c)(1)(v)

a. Reasonable Explanation

If HSRI determines that an applicant's explanation for the discrepancy between their 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 Eligibility²²¹

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 ninety (90) days to submit satisfactory documentation to verify their income.²²² During this 90-day period, customers receive conditional coverage and financial assistance.²²³ 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.²²⁴ Additionally, applicants may have to pay back any tax credits paid on their behalf during this period.²²⁵

If the applicant does not provide satisfactory income documentation within the required ninety (90) days, and the applicant is not granted a good faith extension,²²⁶ then the applicant's final eligibility will be based on available data sources.

B. Data Matching

1) Overview of Data Matching

HSRI will attempt to verify an applicant's eligibility information through a variety of state and federal data sources.²²⁷ 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 (SSA) data. Immigration status will be verified against data from the Department of Homeland Security. HSRI will accept self-attestation for some eligibility factors, such as residency or pregnancy (except where the attestation is not reasonably compatible with available information).²²⁸ For these eligibility factors, HSRI 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 HSRI.²²⁹

Customers must give HSRI permission to obtain, use and share confidential information in compliance with HSRI application policies. HSRI 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.

²²¹ This subsection pertains to APTC/CSR eligibility. Refer to [Section E.2](#) of this chapter for more on temporary Medicaid eligibility.

²²² 45 CFR § 155.315(f)(2)(ii)

²²³ 45 CFR § 155.315(f)(4)

²²⁴ 45 CFR § 155.315(f)(5)

²²⁵ 45 CFR § 155.315(f)(4)(ii)

²²⁶ 45 CFR § 155.315(f)(3)

²²⁷ 45 CFR § 155.320(a)-(f); 42 CFR § 435.948(a)-(f); 42 CFR § 435.949(a)-(b); 210-RICR-30-00-5.7

²²⁸ 210-RICR-10-00-3.5

²²⁹ 210-RICR-30-00-5.8

For more information, please refer to HSRI’s application policies available at:
<https://healthsourceri.com/application-policies/>.

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.²³⁰ 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 HSRI.

Table 7.1 below summarizes Rhode Island’s Reasonable Compatibility standards which are discussed further in this section.

Table 7.1 - 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 50% and no more than \$12,000. ²³¹	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 50% or \$12,000. ²³²	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

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 this individual 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 their eligibility would be screened for APTCs and CSRs.

²³⁰ 45 CFR § 155.320(a)-(f); 42 CFR § 435.945(a)-(b)

²³¹ “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 210-RICR-30-00-5.8(B).

²³² “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 210-RICR-30-00-5.8(B).

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

4) Attestation is Lower than Data and the Difference Between Attestation and Data is Less than 50%

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 50% (so long as difference is not greater than \$12,000).²³³ When data obtained by HSRI 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: An applicant attests to an annual income of \$25,000. HSRI verifies the individual's attestation against data sources and shows an income of \$27,000. The difference between the income that the individual attested to, and the data sources is is reasonably compatible; the difference is less than 50% therefore no additional verification of income is required.

5) Attestation is Lower than Data and the Difference Between Attestation and Data is Greater than 50%

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 50%.^{234,235}

Example: An applicant attests to an annual income of \$25,000. HSRI verifies the individual's attestation against data sources and shows an annual income of \$52,000. The difference between the income that the individual attested to, and the data sources is not reasonably compatible because the difference is greater than 50%, so the individual will need to verify their income.

D. Reasonable Explanations for Income Inconsistency

When HSRI finds an applicant's income attestation is not reasonably compatible with available data sources, HSRI may accept a reasonable explanation.²³⁶ 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 list of reasonable explanations for a discrepancy in income in *Table 7.2* below.

²³³ Department of Health and Human Services; Center for Consumer Information and Insurance Oversight. "Annual Income Adjustment Threshold FAQ" July 21, 2016

²³⁴ 45 CFR § 155.320(c)(1)(vi)

²³⁵ HealthSource RI's threshold for annual income data matching issues (DMI) is 50%; <https://www.cms.gov/cciiio/resources/regulations-and-guidance/income-threshold-faq.pdf>.

²³⁶ 45 CFR § 155.320I(2)(i)(B); 42 CFR § 435.952(c)

Table 7.2 - List of Reasons for Potential Income Discrepancies

Reasonable Explanations for a Discrepancy in Income ²³⁷	
<ul style="list-style-type: none"> • Loss of job • Decrease in hours/wages earned • Self-employed • Do not file taxes • Have not filed taxes yet • Homelessness • Victim of domestic violence • Victim of natural disaster 	<ul style="list-style-type: none"> • Fluctuating or inconsistent sources of income • Income from capital gains • Income from dividends • Income from royalties • Seasonal worker • Divorce or marriage • Death in family • 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 additional time to submit satisfactory documentation to verify any outstanding eligibility elements.²³⁸ This is referred to as conditional eligibility. HSRI will provide notice along with instructions and deadlines for submitting any additional documentation that may be required to complete verification of eligibility.

1) Temporary Eligibility for APTC/CSR

Customers who appear to be eligible for a QHP 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 income amount. However, if at the end of the 90-day period the individual is unable to resolve the inconsistency by submitting satisfactory documentation, HSRI will adjust the eligibility for programs or assistance based on available data sources. This change may impact applicants’ 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. An SEP, 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 APTC for which the applicant was 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

Medicaid applicants with discrepancies other than citizenship or immigration status have thirty (30) days provide satisfactory verification in order to proceed with the eligibility determination. Please refer to the most recent Medicaid Rules & Regulations for 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.²³⁹ This evaluation will be conducted on a

²³⁷ 210-RICR-30-00-5.9(B)

²³⁸ 45 CFR § 155.320(c)(3)(vi)(C)

²³⁹ 45 CFR § 155.315(g)

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.²⁴⁰ These requests must be made by calling the HSRI 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. HSRI 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 verification process, applicants will be asked to submit satisfactory documentation to verify eligibility. The following lists summarize acceptable documentation when verifying eligibility.

Identity (First Name/Last Name) ²⁴¹
<ul style="list-style-type: none"> • 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 • Permanent Resident Card • Voter Registration Card
Social Security Number ²⁴²
<ul style="list-style-type: none"> • Naturalization Certificate • Social Security Card • Military Service Records • Alien Card (I-155) • Employment Authorization Card (I-776) • Social Security Records • Federal tax return showing SSN

²⁴⁰ 45 CFR § 155.315(g)

²⁴¹ HealthSource RI Application Field Inventory, Tab B: Accepted Documentation.

²⁴² HealthSource RI Application Field Inventory, Tab B: Accepted Documentation.

Date of Birth ²⁴³
<ul style="list-style-type: none"> • Birth certificate • U.S. Passport • Naturalization Certificate • 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 ²⁴⁴
<ul style="list-style-type: none"> • 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 • Sewer and Water Bills • Non-Heating Utility Bills • Telephone Bills
Income
<ul style="list-style-type: none"> • Pay stubs representative of the last four (4) weeks of income • Earnings Statement • Employment Letter • Bookkeeping Records • Property Unit Proof • Owner Occupied Proof • Monthly Rental Income Proof

²⁴³ HealthSource RI Application Field Inventory, Tab B: Accepted Documentation; 210-RICR-10-00-3.9(A)(3)

²⁴⁴ HealthSource RI Application Field Inventory, Tab B: Accepted Documentation.

- 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 the adult is not deceased, the individual may either present a valid photo ID, in person, to the HSRI Contact Center, or call the HSRI Contact Center and verbally attest on a recorded telephone line to not being deceased.
- 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 Contact Center.

To demonstrate one is deceased:

- Death certificate
- Letter from funeral home
- Obituary

Incarceration²⁴⁵

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 Contact Center or call the HSRI Contact Center and verbally attest on a recorded telephone line to not being incarcerated.

²⁴⁵ Beginning in plan year 2026, HSRI may accept a self-attestation to verify incarceration status.

Citizenship ²⁴⁶	
Primary Evidence: The following evidence must be accepted as satisfactory documentary evidence of both identity and citizenship	
<ul style="list-style-type: none"> • 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</u> citizenship:	PLUS one of these documents to <u>prove</u> identity:
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 the individual became part of the United States or an applicant's statement that the applicant was a resident in one of these locations when the applicant 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

²⁴⁶ 42 CFR § 435.407(a)-(d)

Citizenship ²⁴⁶	
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 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, the applicant 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	

Citizenship ²⁴⁶	
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 ²⁴⁷	
<ul style="list-style-type: none"> • 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-776) • 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 	

²⁴⁷ 210-RICR-10-00-3.9(A)(5)

- 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)
- 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 (AI/AN)

- 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, Advance Premium Tax Credits (APTCs), cost-sharing reductions (CSRs), and Qualified Health Plans (QHPs) must undergo a redetermination of eligibility every twelve (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 twelve (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 (HSRI) 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 HSRI, or that may impact that customer’s eligibility for existing financial assistance in the form of APTCs or CSRs. 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

The following outlines how HSRI 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.

1) **Information Reported by Individuals**

Households must report any change affecting eligibility for IAPs and QHPs.²⁴⁸ These include changes to:

- Citizenship, status as a national, or lawful presence;
- Incarceration status;
- Residency;
- Income;
- Pregnancy;
- Household composition (i.e., a recent birth, death, or adoption); and

²⁴⁸ 45 CFR § 155.330(b)(1)

- Access to other sources of health coverage.

Individuals receiving Medicaid and CHIP must report changes to any of the above within ten (10) days,²⁴⁹ while those enrolled in a QHP with or without financial assistance, must report within thirty (30) days of such change.²⁵⁰

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) 840-4774**;
- **By mail.** At this address: HealthSource RI, 401 Wampanoag Trail, East Providence, RI 02915;
- **In person.** At the HealthSource RI Contact Center at 401 Wampanoag Trail, East Providence, RI 02915.

If an individual reports a change affecting eligibility, DHS and EOHHS will update the account for Medicaid and CHIP eligibility,²⁵¹ and HSRI will update the account regarding eligibility for a QHP, APTCs, and CSRs.²⁵² Customer reported changes may be shared across programs.

EOHHS, DHS and HSRI 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 HSRI Contact Center at **(855) 840-4774**.²⁵³

If a QHP enrollee did not request to be considered for IAP eligibility when the customer applied for coverage (i.e., indicated the enrollee 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 HSRI coverage, for example change in address or incarceration.²⁵⁴

EOHHS, DHS and HSRI will verify any information reported by the individual following the standard verification processes used at application, as described in detail in [Chapter 7](#).²⁵⁵

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

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

²⁴⁹ 42 CFR § 435.916(c)

²⁵⁰ 45 CFR § 155.330(b)(4)

²⁵¹ 42 CFR § 435.916(c)

²⁵² 45 CFR § 155.330(a)

²⁵³ 45 CFR § 155.330(c)(2)

²⁵⁴ 45 CFR § 155.330(b)(2)-(3)

²⁵⁵ 45 CFR § 155.330(c)(1)

Table 8.1 - Data Sources Reviewed after Enrollment to Identify Changes Related to Medicaid/CHIP 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
	The Work Number (TWN)	Data is refreshed each time a worker receives a new pay stub
Death	Social Security Administration (SSA), Local Departments of Health	Real-time to Federal Hub SSA data. DOH state data refreshed weekly & accessed real-time
Incarceration	Department of Corrections, Social Security Administration (SSA)	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

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

For APTC/CSR/QHP eligible individuals, EOHHS, DHS and HSRI will examine a variety of data sources periodically to identify any changes related to:²⁵⁶

- Death;
- Incarceration status;²⁵⁷ and
- Eligibility for Medicare, Medicaid or CHIP for individuals receiving tax credits or CSRs.

a. 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 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 HSRI identifies inconsistency of information relating to income, family size or family

²⁵⁶ 45 CFR §155.330(d)

²⁵⁷ Beginning in plan year 2026, HSRI may accept a self-attestation to verify incarceration status.

composition for QHP-eligible households²⁵⁸ 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 thirty (30) days from the date of the notice to respond and either confirm the information or contest any inaccuracies.

If the individual responds within the 30-day period to contest the accuracy of the information, HSRI will reconcile the inconsistency according to the process outlined in [Chapter 7](#). If the household does not respond within thirty (30) days, HSRI will maintain the enrollee's existing eligibility determination without considering the updated information.

b. Updated Information Related to Nonfinancial Eligibility Criteria Including Death and Incarceration²⁵⁹

If HSRI identifies updated information relating to death or other nonfinancial eligibility factors (all factors other than income, family size or family composition)²⁶⁰ HSRI will send a notice to the household, listing the updated information needed. The customer will have thirty (30) days from the date of the notice to contest any inaccuracies.

If the customer responds within the 30-day period contesting the accuracy of the information, EOHHS, DHS and HSRI 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 the individual's eligibility. It is important to note that updates to an individual's eligibility may have an impact on other household members' coverage.

4) Noticing Related to Reporting Changes

Individuals are notified of their responsibility to report changes within ten (10) days of the change for Medicaid and CHIP, and within thirty (30) days of the change for APTCs, CSRs, and QHP. Individuals receive messages about their obligation to report changes in multiple HSRI notices, including those relating to exemption determination, annual Open Enrollment Period (OEP), 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 to avoid any unintended consequences for their coverage.

5) 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 least fifteen (15) days before the individual's coverage is canceled, or according to the most recent Medicaid Rules & Regulations. If the individual disagrees with the change in eligibility, the individual may request a hearing and aid pending according to the process described in [Chapter 9](#) while awaiting the hearing date.²⁶¹

²⁵⁸ 45 CFR § 155.330(e)(2)(ii)

²⁵⁹ Beginning in plan year 2026, HSRI may accept a self-attestation to verify incarceration status.

²⁶⁰ 45 CFR §155.330(e)(2)(i)

²⁶¹ 42 CFR § 431.211

b. APTC/CSR/QHP Individuals

In general, changes to APTC, CSR, and QHP-eligible individuals and households identified by the last day of the month are effective the first day of the month following the date of the notice.²⁶² 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 8.2 - Changes in Household Status & Corresponding New Coverage Effective Dates

Change	Coverage Effective
Impacts Premiums or Enrollment ²⁶³	First day of the month following that in which the HSRI is notified of the change.
Birth, Adoption, Placement for Adoption or Placement in Foster Care ²⁶⁴	Date of birth, adoption, placement for adoption or foster care.
Marriage or Loss of Minimum Essential Coverage ²⁶⁵	First day of the following month.
Newly eligible for Medicaid or CHIP ²⁶⁶	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 the customer became eligible.

Note: For coverage to be effective as of the time frames provided in the table above, the customer must first report the change, select a plan, and make the first premium payment, all by the last day of the month.

If a change results in a decrease in APTCs or a change in CSR eligibility, and the household notifies HSRI 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 second month following the eligibility redetermination.²⁶⁷

Example: An HSRI enrollee updates their application on September 25th and their APTC decreases from \$195/month to \$145/month. Since the eligibility redetermination was made after September 23rd, the updated APTC would change from \$195/month to \$145/month on November 1st.

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 Table 8.2 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 where the customer has both QHP and Medicaid coverage.**

²⁶² 45 CFR § 155.330(f)(1)(i)

²⁶³ 45 CFR § 155.330(f)(1)(iii)

²⁶⁴ 45 CFR § 155.330(f)(4)

²⁶⁵ Id.

²⁶⁶ 45 CFR § 155.430(d)(iv)

²⁶⁷ 45 CFR § 155.330(f)(3)

Table 8.3 - 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 12 Months 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 OEP
		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 OEP
		Ineligible for all IAP/QHP	Combined notice with Medicaid/CHIP eligibility	n/a

Program Eligibility Prior to Change Report	Eligibility Impact of New Information	Specific Change to Eligibility	Documentation Issued to Consumer	Coverage Effective Date
			termination, right for aid continuing, eligibility denial for other IAPs/QHP	
APTC/CSR	Change in eligibility	Different APTC/CSR level	Notice acknowledges updated account information and indicates there are no changes to individual's coverage	No change to next anticipated annual redetermination date
		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 IAPs²⁶⁸ must be re-determined every twelve (12) months.^{269,270,271} EOHHS, DHS and HSRI 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.²⁷² If EOHHS, DHS and HSRI do not have enough information to redetermine 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/Rlte 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.

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/Rlte Care 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, HSRI will initiate a renewal process prior to the annual OEP each year. Please refer to [Section G](#) of Chapter 3, for more information.

a. Annual Redetermination Notice

HSRI sends an Annual Redetermination Notice²⁷³ to each primary account contact to announce the renewal process and dates for annual OEP.

The renewal notice is sent as a single, coordinated communication with the Annual Open Enrollment Notice containing:

- Dates of the upcoming OEP;
- Description of the annual redetermination and renewal process;
- Any applicable requirement to report changes to information affecting eligibility and

²⁶⁸ Assuming initial eligibility determined using MAGI-based income methods.

²⁶⁹ 42 CFR § 435.916

²⁷⁰ 42 CFR § 457.343

²⁷¹ 45 CFR § 155.335(a)

²⁷² Any databases accessed by the agency under 42 CFR § 435.948, 42 CFR § 435.949, and 42 CFR § 435.956.

²⁷³ 45 CFR §155.335(c)

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 1st of the upcoming coverage year and the payment deadline for the same;
- A brief description of the premium tax credit (PTC) 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, HSRI must obtain authorization for the release of tax return information in order to access updated financial information and re-determine each individual's eligibility for financial help. The individual grants such consent during the application process and may provide an authorization for up to five (5) years. This consent may be found on HSRI's website.²⁷⁴

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 HSRI does not have a valid authorization to access tax data from an individual, it may only conduct a redetermination for QHP eligibility without financial help. Tax data is essential to the determination of eligibility for tax credits and cost-sharing reductions. HSRI may not proceed with the redetermination for IAP eligibility until the individual authorizes access to tax data.

b. Eligibility Redetermination

Each year, HSRI 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 (i.e., family size, income, incarceration, immigration status). The application process used during a renewal will be abbreviated and will be pre-populated with current year application data to the extent possible.²⁷⁵

c. Coverage Effective Date

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.²⁷⁶

D. Enrollment Reconciliation

Pursuant to *45 CFR §155.400(d)*, HSRI is required to reconcile enrollment records with all participating health insurance companies and HHS monthly. Because The Centers for Medicare and Medicaid Services (CMS) pays APTCs and CSRs to health insurance companies based on the enrollment files, it is critical that entities' enrollment data is reconciled. In addition, the enrollment data retained by HSRI 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

²⁷⁴ Available at <https://healthsourceri.com/application-policies/>.

²⁷⁵ Any information reported by a customer will be verified using the processes outlined in 45 CFR §§ 155.315 and 155.320.

²⁷⁶ 45 CFR § 155.335(i)-(j)

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 HSRI or make changes to their coverage, HSRI 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 HSRI, a process called “enrollment data reconciliation” is used. At least monthly, HSRI uses an automated monthly reconciliation process to compare billing and enrollment systems data with health insurance company data.

2) Resolution of Enrollment Discrepancies

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

a. Over-Billed Premiums

HSRI may retroactively correct any over-billed premium amount for an erroneously high premium amount. HSRI 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 HSRI bills an erroneously low premium amount (or does not bill the enrollee at all). HSRI may, within a reasonable time of discovering the under-billing, generate a corrected invoice and duly update the customers’ account balances.

Chapter 9: Enrollment and Eligibility Appeals

A. Overview of HealthSource RI Complaints and Appeals Process

HealthSource RI (HSRI) 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.²⁷⁷ MAGI Medicaid and HSRI appeals are handled in a coordinated manner across HSRI, the RI Department of Human Services (DHS), and the Executive Office of Health and Human Services (EOHHS).²⁷⁸

Applicants and enrollees are entitled to a hearing to appeal the following actions:²⁷⁹

- Whether they are eligible to buy a Marketplace plan, including a Catastrophic Health Insurance plan;²⁸⁰
- Whether they can enroll in a Marketplace plan outside the regular open enrollment period;²⁸¹
- Whether they are eligible for lower costs based on their income;²⁸²
- The amount of savings they are eligible for;²⁸³
- A redetermination of eligibility, including the amount of Advance Premium Tax Credits (APTCs) and level of cost-sharing reductions (CSRs);²⁸⁴
- Whether they were properly terminated or dis-enrolled from a Qualified Health Plan (QHP);²⁸⁵
- Whether they are eligible for an exemption from the requirement to have health insurance;²⁸⁶ and
- Whether employers or employees are eligible for HSRI for Employers;²⁸⁷

HSRI administers Large Employer Appeals,²⁸⁸ including whether the employer provides minimum essential coverage (MEC) 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, HSRI 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 HSRI Contact Center.

²⁷⁷ 210-RICR-10-05-2

²⁷⁸ 210-RICR-10-05-2

²⁷⁹ 220-RICR-90-00-1.4(A)(12)

²⁸⁰ 220-RICR-90-00-1.4(A)(8)

²⁸¹ 220-RICR-90-00-1.4(A)(8)

²⁸² 220-RICR-90-00-1.4(A)(8)

²⁸³ 220-RICR-90-00-1.4(A)(8)

²⁸⁴ 220-RICR-90-00-1.4(A)(8)

²⁸⁵ 220-RICR-90-00-1.4(A)(8)

²⁸⁶ 220-RICR-90-00-1.4(A)(13)

²⁸⁷ 220-RICR-90-00-1.4(A)(29)

²⁸⁸ 220-RICR-90-00-1.4(A)(20)

Complaints may be submitted:

- by phone at **1-855-840-4774**;
- by mail at **HealthSource RI, 401 Wampanoag Trail, East Providence, RI 02915**; or
- by fax to the HSRI Contact Center at **401-223-6317**.

C. Appeals Process Rules

The following outlines the rules governing the EOHSS appeals processes, highlighting any differences between the individual and employer 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 of their choosing and the circumstances under which aid may be continued pending an appeal.²⁸⁹ 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 fifteen (15) business days before the date of action,²⁹⁰ 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.²⁹¹ 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.²⁹²

The same requirement to provide a notice of appeal rights exists for employers and employees applying for eligibility through HSRI for Employers.²⁹³ 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 HSRI for Employers to make a timely eligibility decision.²⁹⁴ If an employer does not include an employee on the Employee Census, the employee will not be eligible for and will not receive a denial of eligibility from HSRI for Employers.²⁹⁵

2) Request for Appeal

Customers must request an appeal within **thirty (30) days** of the date of the notice of eligibility determination.²⁹⁶ The request must be filed or postmarked within the 30-day period. The customer is presumed to have received the notice of action five (5) business days after the date on the notice unless the customer can show that the customer did not receive it within that 5-day period.

Requests for appeals may be submitted:

- In-person to the HSRI Contact Center or the DHS Field Office;
- By telephone through the HSRI Contact Center;
- By fax to the HSRI Contact Center;

²⁸⁹ 42 CFR § 431.206 and NPRM; 42 CFR § 431.210 and NPRM; 45 CFR § 155.515

²⁹⁰ 210-30-00-3.2.2(A)(3)(b)

²⁹¹ 42 CFR § 431.211 and NPRM; 42 CFR § 431.210 and NPRM.

²⁹² 45 CFR § 155.515(b)

²⁹³ 45 CFR § 155.740(e)(2)

²⁹⁴ 45 CFR § 155.740(c)(2) & (d)(2)

²⁹⁵ 45 CFR § 155.710(e)

²⁹⁶ 210-RICR-10-05-2.2.1(A)(9)

- By U.S. Mail to the address indicated on the appeals request form;
- Online by accessing the user’s account and clicking “File an Appeal/Hearing Request” from the home page.²⁹⁷

When submitting an appeal by mail, customers should provide an explanation, and documentation whenever possible, regarding the decision being challenged and why the customer believes the determination is inaccurate.²⁹⁸ 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.²⁹⁹

Because an appeal submitted by an employee covered through HSRI for Employers may impact the employer, the employer will be notified if an employee submits a valid appeal.³⁰⁰

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.³⁰¹

For HSRI for Employers appeals, appellants will receive “desk reviews”, although hearing requests will be considered.³⁰² A “desk review” means the Hearing Officer reviews, and bases their 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 HSRI Contact Center in advance and:

- If the hearing has already been scheduled, this advanced notice shall be given no less than five (5) 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.

²⁹⁷ 210-RICR-10-05-2.2.1(A)(2)

²⁹⁸ Appeals Operations Manual, Rhode Island Unified Health Infrastructure Project, Draft v 1.0 (July 26, 2013) at 14.

²⁹⁹ 45 CFR § 155.520(d)(1)

³⁰⁰ 45 CFR § 155.740(g)(1)

³⁰¹ 210-RICR-10-05-2.3.1

³⁰² 210-RICR-10-05-2.4.5

Upon requesting a desk review, the Appellant forfeits their opportunity for an in-person hearing.

5) Assignment of Authorized Representative (AR)

Appellants have the right to designate an AR to represent them at any stage of an appeal.³⁰³ Designation of an AR may be made in the following ways:

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

For HSRI for Employers appeals, employers and employees may select an AR specifically for an appeal as part of the appeal request. If an employer already has an agent or broker as an AR and does not actively select an AR, the agent or broker remains the AR for the appeal. Employees must actively select an AR for an appeal. All correspondence generated through the EOHHS Appeals Office for an appellant who has designated an AR must be sent to that representative, in addition to the Appellant.³⁰⁴

6) Informal Resolution

The Informal Resolution (IR) process is a fundamental component of the appeals process. HSRI 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 HSRI 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 IR process, their right to a hearing is preserved.³⁰⁵

If the attempt was successful, the customer will be provided an opportunity to withdraw the customer's formal hearing request. If the attempt was unsuccessful, the customer's right to a formal hearing stands and the scheduled hearing date remains unchanged.³⁰⁶ HSRI 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 the Appellant previously provided during the application or IR process.

An IR process for an HSRI for Employers 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.³⁰⁷

7) Withdrawal of Hearing Request

The appeal request must be dismissed if an appellant withdraws the request in writing or by phone.³⁰⁸ When requesting the withdrawal the customer may:

³⁰³ 42 CFR §435.923(a) and (b); 45 CFR §155.505(e)

³⁰⁴ 210-RICR-10-05-2.3.1(F)

³⁰⁵ 210-RICR-10-05-2.2.4

³⁰⁶ Appeals Operations Manual, Rhode Island Unified Health Infrastructure Project, Draft v 1.0 (July 26, 2013) at 24.

³⁰⁷ 45 CFR § 155.740(i)(1)(i)

³⁰⁸ 45 CFR § 155.530; 42 CFR § 431.223; 210-RICR-10-05-2.3.8(C)(2)

- Upload a signed withdrawal request in customer’s online account;
- Call the HSRI Contact Center;
- Request a withdrawal in-person at a HSRI Contact Center by completing a withdrawal request form; or
- Mail or fax a written withdrawal request form to a DHS Field Office or to HSRI.³⁰⁹

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.³¹⁰

9) Abandonment of Hearing Request

A hearing will be dismissed upon determination that it has been abandoned.³¹¹ Abandonment occurs when, without good cause, an individual or their AR 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 the customer may contact the EOHHS within ten days if the customer wishes to reschedule the hearing and can demonstrate good cause for failing to attend the hearing.³¹²

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.³¹³

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 ten (10) business days prior to the hearing date and no later than fifteen (15) days if it is an appeal related to eligibility for APTCs or CSRs.³¹⁴

For appeals related to HSRI for Employers, employers and employees both retain the option to elect a “desk review” in lieu of a hearing.³¹⁵ A desk review means the written submissions and evidence shall be reviewed and a decision will be issued by an EOHHS hearing officer.

HSRI for Employers appellants may request a desk review by notifying the EOHHS Appeals Office or HSRI. If the hearing has been scheduled, the Appellant may schedule a desk review any time at least ten (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

³⁰⁹ 210-RICR-10-05-2.3.8(B)(4)

³¹⁰ 210-RICR-10-05-2.3.1(E)

³¹¹ 210-RICR-10-05-2.3.1(E)

³¹² 210-RICR-10-05-2.3.1(E)

³¹³ 210-RICR-10-05-2.3.1(E)

³¹⁴ 45 CFR § 155.535(b)

³¹⁵ 210-RICR-10-05-2.3.5

must be provided within ten (10) days of the request for desk review or at an agreed upon date between the Appellant and the EOHHS Central Appeals Office.³¹⁶

11) Aid Pending

A customer who files an Eligibility Appeal may be eligible to continue their previous level of eligibility pending appeal.³¹⁷ Aid pending is available to customers who appeal an eligibility redetermination that occurred within thirty (30) days of the date the appeal is filed. The customer must request to receive Aid Pending by telephone to HSRI within thirty (30) days of the eligibility redetermination occurring. Aid Pending is limited to customers appealing an eligibility redetermination.³¹⁸ New applicants who have been denied eligibility may not receive Aid Pending.³¹⁹

Once a customer is determined eligible to receive Aid Pending, HSRI will continue the customer's eligibility for enrollment in a QHP, APTCs and CSRs, as applicable, in accordance with the level of eligibility in 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 Internal Revenue Service (IRS) reconciliation at the end of the tax year. If the Appeal results in a determination that is unfavorable to the customer (i.e., reduces the amount of APTCs for which the customer is eligible) the individual would be liable to repay APTCs for which the IRS determines the individual is not eligible.

12) Supportive Documents

Customers have the opportunity to submit supportive documents in person, online, by mail, or by fax via HSRI. 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 HSRI for Employers. Documents submitted for a HSRI for Employers appeal will be incorporated into the evidence presented.³²⁰

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.³²¹ 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.

For HSRI for Employers appeals, customers are permitted to submit evidence.³²² HSRI will consider requests for an Evidence Packet for HSRI for Employers appeals from appellants whose

³¹⁶ 210-RICR-10-05-2.3.5

³¹⁷ 45 CFR § 155.525

³¹⁸ 45 CFR § 155.330(e)(1)(ii); 45 CFR § 155.335(h)(1)(ii); 78 FR 169

³¹⁹ 78 FR 169

³²⁰ Appeals Operations Manual, Rhode Island Unified Health Infrastructure Project, Draft v 1.0 (July 26, 2013) at 34.

³²¹ 42 CFR § 431.242 and NPRM; 45 CFR § 155.535(d).

³²² 45 CFR § 155.740(j)

appeal will be adjudicated with a hearing.

14) Agency Response

The agency responsible 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.³²³

An interpreter will be made available for individuals needing interpretive services. During the hearing, the customer may present additional documentation and present their case to the 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.³²⁴ 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 their AR) outlining their 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.³²⁵

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.³²⁶ 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.³²⁷ Expedited appeal requests will be reviewed on a case-by-case basis.³²⁸

Expedited appeals are not available for HSRI for Employers-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;

³²³ 42 CFR § 431.205(d); 42 CFR § 431.240; Proposed 45 CFR § 155.505(d); Proposed 45 CFR § 155.535(c); Preamble 4648

³²⁴ 210-RICR-10-05-2.3.1(N)

³²⁵ 210-RICR-10-05-2.3.1(N)

³²⁶ 45 CFR § 155.540(a); 42 CFR § 431.244.

³²⁷ 45 CFR § 155.540(b); 42 CFR § 431.244(f)(3)

³²⁸ Appeals Operations Manual, Rhode Island Unified Health Infrastructure Project, Draft v 1.0 (July 26, 2013) at 12.

- 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 U.S. Department of Health and Human Services (HHS) if the customer remains dissatisfied with the APTC/CSR eligibility determination.³²⁹

EOHHS will issue the written notice of the appeal decision to the customer within ninety (90) days of the appeal request, as administratively feasible.³³⁰ 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.³³¹ 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.³³²

For HSRI for Employers, appeal records must be accessible to the employer for an employer appeal. The appeal record must be accessible to both employers and employees for employee appeals.³³³ Confidential information will be redacted and HSRI for Employers appeals will not be publicly available.³³⁴

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

- Appellant
- Authorized Representative (AR), 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)
- HSRI Legal Counsel and Appeals Team³³⁵
- Employer in the case of an employee appeal with HSRI for Employers.³³⁶

Any decision in favor of the individual shall apply:³³⁷

- 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

³²⁹ 45 CFR § 155.545(a); 210-RICR-10-05-2.3.2

³³⁰ 45 CFR § 155.545(b)(1); 210-RICR-10-05-2.3.2(H)

³³¹ 45 CFR § 155.550

³³² Preamble 4666

³³³ 45 CFR §155.740(o) referencing 45 CFR § 155.550.

³³⁴ Id.

³³⁵ Appeals Operations Manual, Rhode Island Unified Health Infrastructure Project, Draft v 1.0 (July 26, 2013) at 10-11.

³³⁶ 45 CFR § 155.740(m)

³³⁷ 45 CFR §155.545(c)

- 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, HSRI 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) Appendix 9.1 - Sample Appeal Form

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:

_____ Medicaid
 _____ Private Plan - HealthSource RI
 _____ Both/Unsure

Human Services:

_____ SNAP
 _____ RIW
 _____ SSP

_____ GPA
 _____ CHILD CARE

_____ Other (Please explain) _____

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

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

A. Overview of Shared Responsibility Payment & Exemptions

Prior to 2019, the Patient Protection & Affordable Care Act (ACA) required 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.³³⁸ The federal payment was reduced to zero dollars (\$0) for plan year 2019. Beginning in 2020, Rhode Island has a state shared-responsibility payment which will be paid when a taxpayer files their Rhode Island Personal Income Tax Return. Taxpayers must pay the shared responsibility payment for themselves and for any tax dependents who did not have MEC.³³⁹ 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.³⁴⁰

The shared responsibility payment is shown in the following table.³⁴¹ Individuals who are required to make a shared responsibility payment must pay the greater of a set percentage of income above the Rhode Island tax-filing threshold³⁴² 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.

Note: The total shared responsibility payment for the taxable year may not exceed the average of the annual premiums of a bronze plan offered through the HealthSource RI (HSRI).

Table 10.1 - Shared Responsibility Payment

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

After 2016, the \$695 shared responsibility payment may be adjusted for cost-of-living changes.³⁴³

If an individual lacks MEC for the entire year, this individual 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.³⁴⁴ 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 *Table 10.1* above.

Individuals and families may apply for an exemption from this requirement under the ACA codified in

³³⁸ ACA Section 1501; 26 CFR § 1.5000A-1(a)

³³⁹ ACA Section 1501; 26 CFR § 1.5000A-1(c)

³⁴⁰ 26 CFR § 1.5000A-1(b)

³⁴¹ 26 CFR § 1.5000A-4(b)

³⁴² 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.

³⁴³ 26 CFR § 1.5000A-4(b)(iv)

³⁴⁴ 26 USC § 5000A(e)(4)(B)(iii)

Rhode Island General Law. There are several categories of exemptions.³⁴⁵ Eligibility for these exemptions and the application process to apply for an exemption are described in detail below.

B. Minimum Essential Coverage

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 Rhode Island personal income taxes after the end of the year.³⁴⁶

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. *Table 10.2* below lists types of private and government-sponsored health coverage that qualify as MEC.³⁴⁷

Table 10.2 – Coverage that Qualifies as MEC

Private Coverage
<p>Employer-sponsored plan, including:³⁴⁸</p> <ul style="list-style-type: none"> • Group health insurance plan offered by, or on behalf of, an employer to employees.³⁴⁹ • 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;³⁵⁰ • COBRA coverage;³⁵¹ • Retiree coverage;³⁵² and • Plans offered to an employee by a third party, such as a professional employer organization or leasing company, on behalf of an employer.³⁵³
<ul style="list-style-type: none"> • Individual market plan, including a plan purchased through HSRI.³⁵⁴
<ul style="list-style-type: none"> • Grandfathered health plan.³⁵⁵ 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.
<ul style="list-style-type: none"> • Self-funded student health coverage³⁵⁶ (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)

³⁴⁵ ACA Section 1311; 26 CFR § 1.5000A-3

³⁴⁶ 26 USC § 5000A(b)(1)

³⁴⁷ 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.

³⁴⁸ ACA Section 1501; 26 CFR § 1.5000A-2(c)

³⁴⁹ 26 CFR § 1.5000A-2(c)

³⁵⁰ 26 CFR § 1.5000A-2(c)(ii)

³⁵¹ 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.

³⁵² 78 FR 53650

³⁵³ 26 CFR § 1.5000A-2(c)

³⁵⁴ ACA Section 1501; 26 CFR § 1.5000A-2(d)

³⁵⁵ ACA Section 1501; 26 CFR § 1.5000A-2(e)

³⁵⁶ 26 CFR § 156.602(a)

Government-Sponsored Coverage	
Medicare Part A Coverage ³⁵⁷ and Medicare Advantage ³⁵⁸	Medicaid ³⁵⁹ (there are limited exceptions described in detail below)
Certain types of veterans' health coverage ³⁶⁰ and TRICARE military coverage ³⁶¹	Children's Health Insurance Program, also known as Rlte Care ³⁶²
Peace Corps volunteer plans ³⁶³	Non-appropriated Fund Health Benefits Program of the Department of Defense ³⁶⁴
Refugee Medical Assistance coverage ³⁶⁵ that provides up to eight months of coverage for refugees.	State high risk pool coverage ³⁶⁶ (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)

i. 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.³⁶⁷
- 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.

C. 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 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.³⁶⁸

Depending upon the type of exemption being sought, individuals have two ways to seek an exemption – they may apply for an exemption through HSRI or claim the exemption when they file

³⁵⁷ ACA Section 1501; 26 CFR § 1.5000A-2(b)(i)

³⁵⁸ 26 CFR § 156.602(c)

³⁵⁹ ACA Section 1501; 26 CFR § 1.5000A-2(b)(ii),

³⁶⁰ ACA Section 1501; 26 CFR § 1.5000A-2(b)(v)

³⁶¹ ACA Section 1501; 26 CFR § 1.5000A-2(b)(iv). For additional information on veteran's health care programs see 38 USC 17.

³⁶² ACA Section 1501; 26 CFR § 1.5000A-2(iii)

³⁶³ ACA Section 1501; 26 CFR § 1.5000A-2(b)(vi). For additional information on Peace Corps volunteer plans see 22 USC § 2504(e).

³⁶⁴ 26 CFR § 1.5000A-2(b)(vii). This program is also an eligible employer-sponsored plan (78 FR 53651).

³⁶⁵ 26 CFR § 156.602(b)

³⁶⁶ 26 CFR § 156.602(d)

³⁶⁷ 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)).

³⁶⁸ <https://healthsourceri.com/mandate/>

their Rhode Island personal income taxes.³⁶⁹ Notices of the exemption eligibility result issued by HSRI will contain a certificate number.

Customers should keep this number to use when they file their state taxes. State and federal rules determine which of the two routes are available for each exemption.

For more information about types of available exemptions or the process for filing an exemption with HSRI or through your tax filing, visit: www.healthsourceri.com/mandate.

³⁶⁹ <https://healthsourceri.com/mandate/>

Chapter 11: Eligibility for HealthSource RI for Employers

A. **Overview of HealthSource RI for Employers**

The State of Rhode Island operates HealthSource RI (HSRI) for Employers to provide employers with fifty (50) or fewer employees access to Qualified Health Plans (QHPs). Employer eligibility to participate in HSRI for Employers 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.

HSRI for Employers offers two options to employers for providing their employees access to QHPs: 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 they choose through HSRI for Employers.

Unlike individual coverage, employers may enroll in HSRI for Employers to provide coverage to employees at any time during the year. Eligible employees will have a standard election period set by the employer³⁷⁰ once the employer enrolls 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 HSRI for Employers. 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 HSRI for Employers coverage, conditions regarding enrollment periods, ancillary products, broker representation, payment policies, and disenrollments. The Appendix at the end of this Chapter contains information on the Small Business Tax Credit available to certain employers to help them pay for health insurance premiums, as well as information on Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage and "mini-COBRA" coverage for employees.

B. **HealthSource RI for Employers Eligibility & Enrollment Procedures**

Small employers located in Rhode Island can participate in HSRI for Employers 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 HSRI for Employers. This section also distinguishes between information that is needed to determine HSRI for Employers eligibility versus information that is needed to establish an employer account in order for the employer to invite employees to enroll in coverage.

To view plans or get quotes before enrolling, employers, brokers, and other representatives can go to <http://www.healthsourceri.com/employers> and access a side-by side rate sheet. Brokers are also offered a quoting tool. Employer eligibility is integrated with the account creation process, so to actually offer employees health plans available through HSRI for Employers, employers must first create an account.

1) **HSRI for Employers Eligibility Requirements**

An employer must meet the following three requirements to be eligible for HSRI for Employers:

³⁷⁰ 45 CFR § 155.725(c)(2)

- a) Must be a small employer;
- b) Must offer coverage to all full-time employees; **and**
- c) Must have a principal business address or a primary worksite with eligible employees in the service area (in Rhode Island).³⁷¹

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.³⁷² 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.³⁷³

Starting in 2016, a small employer is defined as an employer who employed an average of at least one but not more than fifty (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.³⁷⁴

An employee is defined as any individual employed by an employer.³⁷⁵ The number of employees is determined according to Federal employee counting rules set forth in 26 U.S.C. 4980(H)(2) (see below).³⁷⁶ Employers can utilize the Full-time Equivalent 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 HSRI for Employers.

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

(A) In general. *The term “applicable large employer” means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.*

(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*

³⁷¹ 45 CFR §155.710

³⁷² 45 CFR § 155.710; 80 FR 10869

³⁷³ 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 USC § 300gg-91(d)(6) (the term “employer” has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 [29 USC § 1002(5); 29 USC § 1002(5)]).

³⁷⁴ 45 CFR § 155.20

³⁷⁵ 45 CFR § 155.20; PHS Act, 42 USC § 300gg-91(d)(5); 29 USC § 1002(6)

³⁷⁶ 45 CFR § 155.20; 26 USC § 4980H(2)

(II) the employees in excess of 50 employed during such 120-day period were seasonal workers.

(ii) Definition of seasonal workers. 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) Application of employer size to assessable penalties.

(i) In general. The number of individuals employed by an applicable large employer as full-time employees during any month shall be reduced by 30 solely for purposes of calculating

(I) the assessable payment under subsection (a), or

(II) the overall limitation under subsection (b)(2).

(ii) Aggregation. In the case of persons treated as 1 employer under subparagraph (C)(i), only 1 reduction under subclause (I) or (II) 1 shall be allowed with respect to such persons and such reduction shall be allocated among such persons ratably on the basis of the number of full-time employees employed by each such person.

(E) 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.

(F) 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 thirty (30) or more hours for all of 2023. It increased its full-time staff to fifty-three (53) employees in January 2024. It applies for HSRI for Employers coverage on February 2, 2024, for coverage on March 1, 2024, and includes its current employee count of fifty-three (53). Rhode Island Manufacturing is eligible for HSRI for Employers because its employee count was less than fifty (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.³⁷⁷ Companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation, shall be considered one employer.³⁷⁸

Example: Mimi and Roger own six 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 fifty (50) employees. Each Clam Shack applies for insurance through HSRI for Employers 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 HSRI for Employers may maintain enrollment regardless of the number of employees.³⁷⁹ Employers that enter as eligible employers through HSRI for Employers are “grandfathered” into eligibility until they dis-enroll 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.³⁸⁰ However, HSRI for Employers may not determine an employer ineligible, even if the number of employees at the employer increases beyond fifty (50), so long as the employer is continuously enrolled with HSRI for Employers.³⁸¹

b. Employer Must Offer HSRI for Employers Coverage to All Full-Time Employees³⁸²

To participate in HSRI for Employers, eligible small employers must offer coverage to all full-time employees (FTEs). Employers are permitted to self-attest that all FTEs are offered coverage.³⁸³

c. Employer’s Principal Business Address or an Eligible Employees’ Primary Worksite Must Be Located in the HSRI for Employers Service Area (Rhode Island)

Small employers that have a principal business address in Rhode Island are eligible to participate in HSRI for Employers.³⁸⁴

For companies with operations in Rhode Island and another state, employers have two options:

³⁷⁷ 26 CFR § 414(b); 26 CFR § 414(c); 26 CFR § 414(m); 26 CFR § 414(o)

³⁷⁸ R.I. Gen. Laws § 27-50-3(kk); 26 CFR § 414 (b); 26 CFR § 414 (c); 26 CFR § 414 (m); 26 CFR § 414(o)

³⁷⁹ 45 CFR § 155.710(d)

³⁸⁰ R.I. Gen. Laws § 27-50-3(kk)

³⁸¹ 45 CFR § 155.710(d)

³⁸² As defined in 26 USC § 4980H (c)(4): The term “full-time employee” means, with respect to any month, an employee who is employed on average at least 30 hours of service per week.

³⁸³ The Exchange’s eligibility process allows the HealthSource RI for Employers to accept an attestation by an employer that it will offer coverage to all its full-time employees, (CMS-9989-F, March 27, 2012, p. 18400).

³⁸⁴ 45 CFR §155.710(b)(3)(i)

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

d. No Minimum Participation

Federal regulations permit the state Marketplaces to set participation rate parameters.³⁸⁵ The participation rate refers to the portion of eligible employees who participate in HSRI for Employers, and not participation in a specific QHP or QHPs from a specific issuer. However, HSRI for Employers has elected not to set any minimum participation standard.

2) HSRI for Employers Enrollment Procedures

To enroll with HSRI for Employers, employers must comply (either directly, or through their broker or HSRI for Employers representative) with several operational requirements, including:

- Create an account, select broker (if applicable) and provide Employer Census Information;
- Choose a health plan option;
- Select one dental plan;
- Select contribution amounts; and
- Submit documents and finalize application

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

a. Create an Account & Provide Employer Census Information

i. Employer Account Information

Employers must create a username and password. They must also provide a broad set of account information as part of the application process including:

- First and last names;
- Company name;
- Number of FTEs;
- Business and Mailing Address(es);
- Primary phone number and type;
- Email address; and
- Selection of a broker (if applicable).

In addition, employers must also provide an Employer Identification Number (EIN), Employee Census, and Employer Tax and Wage reports, which are addressed in more detail below.

³⁸⁵ 45 CFR §155.705(b)(10)

ii. Employer Identification Number

To enroll in HSRI for Employers, businesses must provide a valid EIN.³⁸⁶ If an EIN is not provided, the Employer/Broker may not finalize the account application.

iii. 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 [Section C](#) of this Chapter 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.³⁸⁷

Employer account creation cannot continue for the employer without having complete account information (i.e., employee's spouse's social security number is missing).³⁸⁸

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 (SEP). The employer may either use the census template to upload the information, enter it manually or provide the census template by email.

b. Employer Chooses a Health Plan Option

Eligible employers who have successfully created accounts must provide certain coverage determinations prior to HSRI for Employers notifying employees of such coverage. Employers must choose either the "Single Plan" option or the "Full Employee Choice" option. While "single plan" and "full choice" are the models available to employers, HSRI for Employers will also work with employers to highlight a narrower list of plans upon request.

i. Single Plan Option

The employer selects one health plan which is the only plan that eligible employees and their dependents may enroll in.

ii. Full Employee Choice Option

Eligible employees may enroll in any plan offered through HSRI for Employers. Employers selecting Full Employee Choice must select a reference plan. The reference

³⁸⁷ R.I. Gen. Laws § 27-50-3(j)

³⁸⁸ The data elements on the employer census are: Last Name, First Name, Eligibility Type (i.e., 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.

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.

c. Employer Contribution Options

An employer has two contribution options to choose from with HSRI for Employers. This determination is completed at the time the employer application or renewal is submitted. Employers may switch from composite rate-based contribution to list bill-based contribution and vice versa upon annual renewal of the plan coverage.

i. Option 1: Composite Rate Contribution

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.

ii. Option 2: List Bill Rate Contribution

The employer shall pick a reference plan and select a contribution percentage of the reference plan list bill premium for employees and a separate percentage for dependents. Employers may select a different contribution percentage for employees and dependents in each of the three contribution groups. A minimum medical contribution for employees is 50%. There is no minimum contribution required for dependents. Each employee can have a different dollar amount for employee and employer contribution, based on their age. If an employee picks a different plan than the employer chosen reference plan, the employee pays (or saves) the difference, while the employer contribution remains constant. If the employer contribution is higher than the plan rate, then the employer share shall adjust down to the plan total and the employee share is zero dollars (\$0). If an employer selects the List Bill Contribution option, List Bill will be used for both medical and dental.

d. Employer Selects One Dental Plan

After selecting a health plan, the employer may select exactly one dental plan. Pricing for dental plans will be separate from medical plans. Employer contribution is optional for dental plans.³⁸⁹ If an employer chooses not to contribute to dental coverage, employee rates will be calculated in a "list bill" manner; each employee will instead have rates specific to that employee and any dependents who are enrolling. Some medical plans may include embedded dental coverage.

³⁸⁹ The contribution is performed such that each employee would pay the same amount for coverage if enrolled in the reference plan.

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

e. 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.³⁹⁰ This minimum amount is required to be contributed to each type of family tier.

The following are tier “levels” recognized by HSRI for Employers:

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

HSRI for Employers 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.³⁹¹

f. Submit Documents and Finalize Application

Finally, the employer submits a *Quarterly Tax and Wage Form*, which can be used to verify the employment status of the employees listed on the census. A *Quarterly Tax and Wage Form* must be submitted at least once every two years for renewals. If a *Quarterly Tax and Wage Form* is not available, please refer to the appendices to this chapter for alternative documentation to submit. The employer finalizes their application by reviewing their application information and providing an electronic signature.

C. Employee Eligibility Requirements and Enrollment Procedures

1) Employee Eligibility Requirements

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 and Wage report, additional supporting documentation may be requested by HSRI. Employers may choose to include the dependent(s) of employees on the Employer Census. As explained above in [Section B.2](#), 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 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 to renew through the employee’s plan (unless disabled), and must seek an alternative source of coverage. When a dependent “ages out” of coverage, HSRI will send the dependent a

³⁹⁰ The contribution is performed such that each employee would pay the same amount for coverage if enrolled in the reference plan.

³⁹¹ R.I. Gen. Laws § 28-5-7(1)(ii)

disenrollment notice and will disenroll the dependent at the end of the plan year.

2) Employee Enrollment Procedures

Similar to employer eligibility, there are several operational requirements for employees to successfully effectuate enrollment in a health plan through HSRI for Employers once they have been determined eligible. The employee will receive notification that their employer registered for HSRI for Employers and that the employee and any dependents are eligible for coverage.

Employees must then:

- a. Create an account;
- b. Review membership information;
- c. Select a health plan;
- d. If applicable, select a dental plan (or choose not to enroll in a dental plan);
- e. Optionally select a PCP for health plan chosen; and
- f. Provide an electronic signature.

a. Create an Account

When the employee is present on the census, the employee proceeds to create an account. The employee must create a username and password.

b. Review Membership

i. Employee Information

Employees will have the opportunity to review their demographic information on the “Review Membership” page, including first name, middle name, last name, suffix (i.e., Sr., Jr., etc.), gender, date of birth, Social Security number, address, phone number and type, and e-mail. In addition, the employee must confirm if the employee is enrolling in medical and/or dental. There will be a checkbox next to each plan type, based on the selection the employee provided to the employer.

ii. Dependent Information (if applicable)

Each employee must review dependent information. The employee can also add and/or remove a dependent. Based on the relationship, the family type will be determined, and a correlating premium applied. For example, if an employee enrolls themselves and their spouse and no children, the plan type and pricing will be based on the family type “employee & spouse.”

If requested by the employer, the employee must be able to provide proof of the insurable relationship.³⁹² An employer may request that HSRI for Employers remove an employee or dependent who is not eligible, as determined by the employer. Employee and dependent eligibility are determined by the employer in the event of a dispute.

c. Select a Health Plan

As described in [Section B.2.b](#) above, the employer determines whether one or more plans are

³⁹² R.I. Gen. Laws § 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-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.

offered to employees.

i. 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.

ii. Full Employee Choice Option

If the employer has selected the full employee choice option, the employee is notified of the reference plan. The employee may enroll in any available plan offered through HSRI for Employers. The employee will be responsible for paying their contribution based on the determined contribution option chosen by the employer. While single choice and full choice are the models available to employers, HSRI for Employers will work with employers to highlight a narrower list of plans by request.

d. Select a Dental Plan (if applicable)

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 by going back to the “Review Membership” page and unchecking dental.

e. Option to Select a Primary Care Provider (PCP) for the Health Plan

After health and dental plan selection, an employee will have the ability to select a PCP for the chosen medical plan. The “Find a Doctor” tool can be used to find participating providers.

f. Provide an Electronic Signature

The employee must provide an electronic signature acknowledging the terms and conditions of submitting application.

3) Qualifying Events for Special Enrollment Periods (SEPs)

HSRI for Employers must provide employees and dependents with SEPs when individuals meet the requirements listed below.³⁹³ Employer-provided information can determine whether employees (or their dependents) qualify for an SEP.

Newly qualified employees must receive an enrollment period starting on the first day of becoming eligible to enroll in HSRI for Employers.³⁹⁴ According to federal rules, the probationary period (“waiting period”) for employee eligibility cannot exceed ninety (90) days. It is the employer’s responsibility to maintain records of employee hire dates and administer the probationary period.

Individuals are eligible for an SEP if they meet one of the following criteria:

- a.** A qualified individual becomes newly eligible for coverage (i.e., is newly hired or becomes eligible based on hours worked.)
- b.** A qualified individual or dependent loses minimum essential coverage; failure to pay premiums is not considered a loss of minimum essential coverage.³⁹⁵
- c.** A qualified individual gains a dependent or becomes a dependent through marriage, birth,

³⁹³ 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)

³⁹⁴ 45 CFR § 155.725(g)

³⁹⁵ 45 CFR § 155.420(e)

adoption or placement for adoption or foster care;

- d. 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 HSRI, or its instrumentalities as evaluated and determined by HSRI. In such cases, HSRI may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
- e. Enrollee adequately demonstrates to HSRI that the QHP in which this individual is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- f. A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;
- g. An American Indian or Alaskan Native, as defined by *Section 4* of the *Indian Health Care Improvement Act*, may enroll in a QHP or change from one QHP to another one time per month;
- h. It has been determined by HSRI that the qualified individual/dependent was not enrolled in a QHP or was not enrolled in the QHP this individual/dependent selected (by a non-Marketplace entity providing enrollment assistance/activities);
- i. A qualified individual or enrollee demonstrates to HSRI, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as HSRI may provide;
- j. 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 the 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 an SEP to reselect a QHP.

D. Employer & Employee Enrollment Periods

Employers may enroll in HSRI for Employers at any time during the year. For employees, the HSRI for Employers enrollment period differs from the HSRI Individual Marketplace; the latter has a set Open Enrollment period (OEP) each year. HSRI for Employers has employer-specific annual OEP held throughout the year and in accordance with the employer's plan year.

Qualified employees can enroll in an eligible employer-sponsored plan during their employer's initial OEP, during the employer's annual OEP, and during SEPs for which they may qualify. New employees wishing to enroll in an eligible employer-sponsored plan can 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, HSRI for Employers will process the employee applications and facilitate the enrollment of qualified employees in QHPs.

1) Annual Open Enrollment Period

HSRI for Employers features an annual OEP for qualified employees prior to the completion of the applicable plan year.³⁹⁶ HSRI for Employers provides notification to each qualified employee of the annual OEP in advance of such period,³⁹⁷ during which any eligible employee may make changes to their enrollment. Changes include enrolling in new coverage, changing plans, changing covered

³⁹⁶ 45 CFR § 155.725 (e)

³⁹⁷ 45 CFR § 155.725 (f)

family members (enrolling or disenrolling dependents), enrolling in a dental plan, and other changes.

2) Effective Coverage Dates for Annual Open Enrollment

HSRI for Employers effective dates of coverage for all qualified employees are consistent with the coverage effective dates established during the initial OEP.

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

3) Newly Qualified Employees

Employer sponsored employees who become eligible outside of the initial or annual OEP are entitled to an enrollment period lasting thirty (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 current month, 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 15th. This individual's enrollment period will last from May 15th through June 15th. If the cashier chooses to enroll on June 12th, their effective date of coverage would be June 1st, or July 1st depending on what the grocery store owner prefers.

4) Special Enrollment Periods

HSRI for Employers grants flexibility to employers to determine the duration of SEPs for qualified employees and dependents of qualified employees to enroll in or change plans.³⁹⁸ A dependent of a qualified employee is not eligible for an SEP if the employer does not extend the offer of coverage to dependents.

Example: An employee was not enrolled in their restaurant's HSRI for Employers plan because they qualified for Medicaid. If their income increases and they no longer qualify for Medicaid starting July 1st, the employee will qualify for an SEP lasting until September 1st, during which they may enroll in an employer-sponsored plan.

a. Regular Effective Coverage Dates for Special Enrollment Periods

At the employer's discretion, the issuer (health insurance carrier) and HSRI for Employers 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 18th. If the florist chooses to enroll within the SEP, their new spouse's effective date of coverage would be September 1st, or depending on the election of the employer, it could be retroactive to August 1st.

³⁹⁸ HSRI for Employers practices may differ from 45 CFR § 155.725(j)(3) in regard to Special Enrollment Period durations.

b. 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, HSRI for Employers must ensure that coverage is effective on the date of birth, adoption, or placement for adoption.

Example: Consider a baby is born, adopted, or placed for adoption on July 24th. The baby's effective date of coverage would be July 24th.

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 with HSRI for Employers. For employers choosing to work with brokers to assist in enrollment and other processes, brokers will maintain the same traditional functions. With HSRI for Employers, 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 or in writing.³⁹⁹ Without authorization, which is considered legally binding by HSRI for Employers, 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.

To be designated the authorized broker, following requirements must be met:

a. Broker must be certified

Broker certification requires that the broker pass a training course provided by an Exchange Broker Liaison. The broker receives a broker certification number, which will be recognized by HSRI for Employers.

b. Broker must have an account.

A broker may create a broker account any time after completing the HSRI for Employers certification process.

c. Privacy

The 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.

d. Duration.

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

- The employer designates an alternative broker.⁴⁰⁰

³⁹⁹ 78 FR 42313; 45 CFR § 155.227(g)

⁴⁰⁰ 45 CFR §155.227(d)(1)

- The employer notifies HSRI for Employers that the Authorized Representative is no longer authorized to act on the employer behalf.⁴⁰¹
- The Authorized Representative notifies HSRI for Employers that the representative will no longer act on behalf of the employer.⁴⁰²
- The Authorized Representative's HSRI for Employers account is closed.
- The Authorized Representative loses their certification.

2) Broker Functions on Behalf of an Employer

An employer's assigned broker may perform all HSRI for Employers 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 of their broker that the broker restrict themselves by only performing a subset of HSRI for Employers functions. The following are typical examples of actions that brokers may perform on behalf of an employer:

- Create Account
- Plan Selection
- Manage Employer Census

3) Broker and Employer Function on Behalf of an Employee

An employer's broker may perform all HSRI for Employers 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 restrict him/herself by only performing a subset of HSRI for Employers 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
- Plan Selection
- Report Qualifying Events

4) Broker - Related Assistance Not Requiring Authorization

Brokers do not require formal authorization from HSRI for Employers to assist employers and employees in matters related to health insurance coverage, but not related to HSRI for Employers. 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 available through HSRI for Employers. Brokers may also assist employees with requesting SEPs from employers and ensuring eligibility for COBRA. Brokers may quote an employer without first being authorized.

F. Termination from HSRI for Employers

This section addresses termination (disenrollment) from HSRI for Employers for both employers and employees. Enrolled employers and employees can leave HSRI for Employers at any time. This is often called a voluntary termination. Other terminations can be caused by several factors, including non-

⁴⁰¹ 45 CFR §155.227(d)(2)

⁴⁰² 45 CFR §155.227(d)(3)

payment of premium or loss of eligibility. Federal regulation and Rhode Island policies set requirements around terminations. Federal regulations require issuers to maintain records of all terminations.⁴⁰³

1) Employer

a. Termination Due to Failure to Pay Premiums

Employers have a two-month grace period before insurers are permitted to terminate the employer's coverage. Payment made during that time period prevents termination. HSRI may terminate coverage if no payment is made by the end of the two-month grace period.

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 23rd, but John's Bait Shop did not pay their bill by February 28th. Coverage for the bait shop will be terminated effective February 28th.

In event of adjustments to billing (i.e., 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 the employer was 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.

b. Termination Due to Loss of Eligibility

HSRI for Employers only permits employers who either have a primary business address or have employees whose primary business location is in the state of Rhode Island to participate in HSRI for Employers. If HSRI for Employers 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

HSRI for Employers must permit an employer to disenroll from coverage.⁴⁰⁴ Employers must contact HSRI for Employers to disenroll the group. HSRI for Employers must confirm that any outstanding payments are made before disenrollment. The employer's termination request must be in writing and received by HSRI for Employers prior to the first day of the next month. The completion of the disenrollment occurs when HSRI for Employers provides the employer with a confirmation of disenrollment. Terminations cannot be requested directly from the carrier.

⁴⁰³ 45 CFR § 156.270(h)

⁴⁰⁴ 45 CFR § 155.430(b)(1)

d. HSRI for Employers Group Reinstatements

As mentioned above, employer groups can be terminated for non-payment if they are more than two months behind on payment. If a group is terminated for non-payment, but within thirty (30) days following termination requests reinstatement, that group may be reinstated under certain conditions.

- i. 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, HSRI for Employers 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 calendar year.
- ii. 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, HSRI for Employers 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 Eligible

HSRI for Employers may initiate disenrollment from coverage if the enrollee is no longer eligible for coverage.⁴⁰⁵ 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 given a notice of termination including the reason for termination and the termination effective date.⁴⁰⁶ The employer must also notify the HSRI for Employers 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 [Appendix 11.2](#) at the end of this Chapter.

b. Employer Disenrolls from HSRI for Employers

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 through HSRI for Employers. In addition, as described in [Appendix 11.2](#), the employee would not be eligible for continuation coverage because the group health no longer exists.

c. Employee-Led Termination (Voluntary Termination)

HSRI for Employers must permit an enrollee to disenroll from coverage.⁴⁰⁷ 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.

⁴⁰⁵ 45 CFR § 155.430(b)(2)

⁴⁰⁶ 45 CFR § 156.270(b)

⁴⁰⁷ 45 CFR § 155.430(b)(1)

G. Premium Payments

Premium payments and billing are discussed in detail in [Chapter 12](#).

H. Ancillary Products

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

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

I. Appendix 11.1 - Small Business Tax Credit

1) Overview

Section 45R of the Internal Revenue Code allows certain small businesses purchasing health insurance on behalf of employees through HSRI for Employers to be eligible for tax credits for the first two years they offer coverage through HSRI for Employers.⁴⁰⁸ The credit has been available to employers meeting the same standards in years prior to the launch of HSRI for Employers.

Certain small employers are eligible to receive a small business tax credit under the Affordable Care Act (ACA) to reduce the effective cost of contributing to health insurance coverage.

2) General Eligibility for Small Business Tax Credit

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

- Employ no more than twenty-five (25) FTEs;⁴⁰⁹
- 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% of the cost of premiums for all employees eligible for coverage.⁴¹⁰

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.⁴¹¹

3) 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% of the employer portion of the premium for taxable employers. The full credit is 35% 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 ⁴¹²	
Tax exempt business	35%
Taxable business	50%

⁴⁰⁸ 26 USC § 45R

⁴⁰⁹ FTE calculation for the small business tax credit is different than FTE count for HealthSource RI for Employers eligibility.

⁴¹⁰ 26 USC § 45R(d)

⁴¹¹ See IRS Notice 2010-082, available at <https://www.irs.gov/pub/irs-drop/n-10-82.pdf>

⁴¹² 26 USC § 45R(b)

4) Phase Out of Small Business Tax Credit

The tax credit is based on a sliding scale with the full amount available to employers with ten (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 HSRI for Employers, the tax credit is reduced from 50% at \$25,000 in average wages to 0% 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% at ten (10) FTEs to 0% at twenty-five (25) FTEs.

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

5) 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 <div style="font-size: 24pt; font-weight: bold; text-align: center;">2014</div> 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	

J. Appendix 11.2 - Continuation of Coverage

1) Overview

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 (20) or more employees,⁴¹³ but many states, including Rhode Island, have established laws to extend similar rights to employees of employers with fewer than twenty (20) employees.⁴¹⁴

2) COBRA

The basic rule under COBRA is that a group health plan of an employer with twenty (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 eighteen (18) months. If a second qualifying event, other than the employer’s bankruptcy, occurs within the first eighteen (18) months, the continuation coverage may be extended for a

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 the COBRA continuation right under the terms of the PHS Act.

⁴¹⁴ R.I. Gen. Laws § 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

total of thirty-six (36) months.

- If the employee becomes disabled either prior to becoming COBRA eligible or within the first sixty (60) days of being covered under COBRA, then the employee and non-disabled family members who are qualified beneficiaries, are eligible for up to an eleven (11) month extension of COBRA continuation coverage, for a total of up to twenty-nine (29) months.
- For other qualifying events, the coverage must continue for thirty-six (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% administrative fee. That means the premium can be as high as 102% of the cost of coverage for similarly 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 forty-five (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 later of the date coverage would terminate because of a qualifying event, or the date notice is provided to the beneficiary, and lasts at least sixty (60) days.⁴²⁰ Coverage is effective on the date of the qualifying event, so coverage may be instituted retroactively.⁴²¹

3) 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 eighteen (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 HSRI for Employers 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 (30) days of the layoff or death.⁴²³

⁴¹⁸ ERISA § 602; PHS Act § 2202

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 R.I. Gen. Laws § 27-19.1-1(h)

⁴²³ R.I. Gen. Laws § 27-19.1-1(a)-(c)

K. Appendix 11.3 - 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 for Employers requires the most recent <i>Form 941</i> (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 Months	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 (i.e., ADP or Paychex)	Most recent payroll report from a third-party payroll processing company (i.e., 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 (i.e., ADP or Paychex)	Most recent payroll report from a third-party payroll processing company (i.e., ADP or Paychex) OR Copy of Business Application and Registration form submitted to RI Division of Taxation
Partnerships	For Employees Who Are Partners	For Employees Who Are Partners
(General partners will not have <i>Form 941</i> or <i>W-2</i> . Income information is found on <i>Schedule K-1</i> – line 15A)	<i>Schedule K-1</i> (Partner's Share of Income) OR <i>Schedule SE</i> (Self-employment Tax) OR <i>Form 1065</i> (Partnership Return of Income) AND For employees who are not partners: <i>Form 941</i> (Quarterly Tax and Wage Report) OR Most recent payroll report from a third-party payroll processing company (i.e., 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 (i.e., ADP or Paychex)
Limited Liability Company (LLC)	<ul style="list-style-type: none"> • May file as a C-Corp or a Partnership • Determine which one and see requirements above. 	<ul style="list-style-type: none"> • May file as a C-Corp or a Partnership • Determine which one and see requirements above.
Independent Contractors		
	<i>Form 1099-MISC</i>	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 (i.e., 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: Qualified Health Plan (QHP) Terminations and Billing

A. Introduction

This Chapter will detail the policies, procedures and rules governing terminations, billing, and late payment in the HealthSource RI (HSRI) individual and HSRI for Employers markets.

B. Termination of Coverage in the Individual Market

Issuers (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, the issuer may request that termination be initiated by HSRI by providing notice to HSRI in writing or in such other format as HSRI may determine, but the termination must be completed by HSRI. Upon examination and successful validation of such request, HSRI will initiate such termination and provide notice of termination to the enrollee and the health insurance company.

1) Involuntary Termination: HSRI may initiate the termination of an enrollee's coverage in the following circumstances⁴²⁶:

- The enrollee is no longer eligible for coverage through HSRI;
- The enrollee did not pay their 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: Jamie moves out of the state of Rhode Island and reports this change to HSRI. Jamie is no longer eligible for coverage through the QHP. HSRI will terminate Jamie's coverage at the end of the month in which Jamie reports this change.

2) Voluntary Termination: An enrollee may request to terminate health coverage in a QHP at any time, including because the enrollee has obtained other minimum essential coverage.⁴²⁷ An enrollee may terminate their coverage through the customer's online account, or by calling or visiting the HSRI Contact Center. The effective dates of terminations are described in [Section E](#) of this Chapter.

3) Enrollee Age-Out: The maximum age of a child dependent on a health insurance policy at the time of enrollment is 25 years old. When a child dependent turns 26, they will be unable to renew on the shared policy and will need to go onto their own health insurance policy for the upcoming year.⁴²⁸

C. Reinstatements

If an enrollee is terminated due to lack of premium payment, but within thirty (30) days following termination requests reinstatement and pays all premiums owed including any prior premiums owed

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)

⁴²⁸ 45 CFR § 155.430(b)(3)

for coverage during the grace period, HSRI will reinstate the enrollee's coverage. An enrollee may be reinstated only once per calendar year.

D. Notification

Upon termination, HSRI 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 prior to the last day of coverage for any form of involuntary termination.⁴²⁹ 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 will be sent by mail or digitally via the customer portal with email notification depending on a customer's notification preference. The termination notice will be sent to the primary account contact and will be available in the customer portal. 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.

E. Effective Dates for Termination of Coverage

Coverage through HSRI is offered in one-month intervals. HSRI 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 following⁴³⁰:

- The last day of the month during which termination is requested by the enrollee; 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 their new QHP, including any retroactive enrollments; or
- If enrollee demonstrates to HSRI that the enrollee has active dual coverage, the enrollee may request an alternative QHP termination date of the last day of the month prior to the request. This is meant to accommodate requests within one month of the new coverage becoming effective. Cases under this policy will be handled on a case-by-case basis by HSRI.

In the case of a termination due to the individual becoming ineligible for coverage in a QHP through HSRI, the last day of coverage will be the last day of the month following the month that HSRI 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 thirty-day prorating rule. The premium payable for that terminated enrollee shall be calculated

⁴²⁹ 45 CFR § 156.270 (b)(1)

⁴³⁰ 45 CFR § 155.430(d)(1)-(2)

⁴³¹ 45 CFR § 155.430 (d)(3)

⁴³² 45 CFR § 155.430(d)(7)

as follows: ***(Total Days of Coverage Received / 30) x Full Monthly Premium***

Example: An individual was paying \$240 per month for their premium. If this individual dies on July 20th, their coverage would be terminated on July 20th and their premium would be pro-rated using the calculation as follows:

$$(20/30) \times \$240 = \$160$$

The premium payable for this individual would equal \$160.

In the case of a termination due to non-payment of monthly premium, individuals enrolled in QHP coverage will receive a three-month grace period. The last day of coverage will be the last day of the first month of the three-month grace period if all outstanding premiums are not paid by the last day of the grace period.

Example: Barbara is enrolled in QHP coverage and fails to make a premium payment for May coverage by the April 23rd deadline. Barbara has until July 31st to pay the outstanding balance on the account. If payment for the past due balance is not received by July 31st, Barbara's coverage will be terminated effective May 30th.

For all other cases of involuntary termination, HSRI shall set the effective date of termination in accordance with applicable law.⁴³³

Example: Megan wishes to voluntarily terminate coverage and submits the request to HSRI on May 10th. The effective date of termination will be May 31st.

Example: Edward has become eligible for Medicaid with a coverage effective date of April 1st. Edward's existing coverage will be terminated by HSRI on April 30th.

Example: Sandy is re-determined by HSRI to be ineligible for coverage through a QHP and is notified of this redetermination on September 18th. Barring a request to provide additional documentation in support of eligibility, the last day of Sandy's coverage will be September 30th.

Example: Deb is enrolled in a QHP that has been decertified and can no longer purchase coverage through HSRI. HSRI will terminate Deb's coverage and 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 (an SEP) within which Deb will be able to select a new QHP.

F. Grace Periods Ending After the Annual Open Enrollment Period Closes

A grace period for non-payment of premiums may extend past the end of the annual Open Enrollment period (OEP) if an enrollee fails to pay their premium in full for November or December coverage in a timely manner. For both auto-renewal and active plan selections that are continuations of the same coverage, HSRI may attribute payments to the oldest outstanding debt in the existing grace period. If the enrollee does not pay all outstanding premiums by the end of the three-consecutive-month grace period, HSRI may terminate the enrollee's coverage retroactively to the last day of the first month of the

⁴³³ 45 CFR § 155.430(a)

grace period.⁴³⁴ If coverage for January is not paid by December 31st, then coverage for the new plan year may also be canceled.

G. Effective Dates for Termination of HSRI for Employers Coverage

Federal regulations grant HSRI for Employers the flexibility to determine the timing in which coverage in a QHP may be terminated.⁴³⁵ Terminations from HSRI for Employers 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

H. Retroactive HSRI for Employers 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 HSRI for Employers.⁴³⁸

I. Billing

HSRI's financial management system is the system of record for transactions related to billing and payment for coverage purchased through HSRI.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. Danielle plan costs \$154. Danielle must pay \$154 by January 23rd to be considered paid in full for the month of February.

1) Initial Invoices

Initial billing invoices are sent during annual OEP and Special Enrollment Periods (SEPs). 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 their communication preference, the invoice is also mailed to the address on record for the customer (or their 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 HSRI flexibility to establish a deadline relative to the OEP by which an individual’s first month’s premium must be received to make coverage effective as of the first day of the upcoming coverage year.⁴⁴⁰ HSRI may

⁴³⁴ Consistent with 45 CFR §§ 156.270 and 155.430

⁴³⁵ 45 CFR § 155.735(a)

⁴³⁶ 45 CFR § 155.735(a)

⁴³⁷ 45 CFR § 155.735(a)

⁴³⁸ 45 CFR § 155.735(a)

⁴³⁹ 45 CFR § 155.240(c)

⁴⁴⁰ 220-RICR-90-00-1.6(C)

or may not extend the payment deadline in a given Open Enrollment Period. Customers should refer to their Annual Open Enrollment Notice or www.HealthSourceRI.com for updated information regarding payment dates.

Example: Mariam has made a plan selection on November 20th during OE and selected an effective coverage date of February 1st. An initial invoice will be generated and mailed to Mariam in December. The payment due date on the invoice will be January 23rd.

2) Ongoing Invoices

Ongoing invoices for both individuals and employers 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 HSRI. An invoice will be generated and mailed to Matt in early February and the full balance on that invoice will be due on the 23rd of February for the coverage month of March.

J. Payment Options

HSRI 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 their HSRI online portal. The check or money order and statement must be mailed to: **HealthSource RI, P.O. Box 9711, Providence, RI 02940-9711.**
 - For HSRI for Employers, the check or money order must be mailed to: **HealthSource RI for Employers (HSRIER), DEPT #350, PO BOX 9717, Providence, RI 02940-9717.**
- **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 HSRI 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 the customer's invoice. If it does not appear on an invoice, the customer needs to log into their online account or contact HSRI to confirm the payment account information is correct. If the invoice does not show a customer has recurring payments, the customer 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 HSRI and may require extra processing time and/or result in disruptions to coverage.

- ***In person:***

- Customers wishing to hand-deliver payments can do so at the HSRI Contact Center at: **401 Wampanoag Trail, East Providence, RI 02915**. The HSRI Contact Center can only collect check or money orders; cash or electronic payments will not be accepted at the HSRI Contact Center.
- Customers also have the option to pay in person at most CVS locations nationwide.⁴⁴¹
- For HSRI for Employers, customers wishing to hand-deliver payments can do so at: **HealthSource RI for Employers at 20 Newman Avenue, Suite 1000, Rumford, RI 02916**.

Note: 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 making reasonable efforts, then the unclaimed funds will escheat to the State of Rhode Island as unclaimed property. After this point, HSRI 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.

K. 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 OEP 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.⁴⁴²

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 HSRI Contact Center. Note customers who have been disenrolled for non-payment will not be able to enroll in coverage until the next annual OEP unless they experience a qualifying life event.

L. Making a Payment

⁴⁴¹ CVS locations in Target stores are excluded. There may be limitations on the amount payable per transaction per twenty-four hour period.

⁴⁴² 45 CFR § 156.270

Customers may make payments directly through their online HSRI 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 twenty-four (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. Generally, a recurring payment can be set up after a customer has paid their first invoice in full. Recurring payments are typically drafted on the 18th each month. For new enrollees, recurring payments set up by the 17th of the month will be accepted as a binder payment. If recurring payments are set up after the 17th of the month, then the amount shown on the most recent billing invoice must first be paid using one of the other payment options. Once the initial payment is processed, recurring payments will begin the following month. 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 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 to ensure there is no disruption to coverage.

HSRI will consider a customer paid if their initial payment for the year is within five dollars (\$5.00) of the amount owed, and for subsequent months if the balance owed is less than ten dollars (\$10.00). A customer may be liable to pay back any tax credits paid out for any months of coverage where the customer does not pay their full share of the premium. For example, if a customer has not paid full premiums for coverage months June and July, but the balance due for those two months is less than ten dollars (\$10.00), coverage may not be terminated by HSRI for non-payment of premiums, however the customer may be liable to pay back Advance Premium Tax Credits (APTCs) for those two months when filing their federal income taxes.⁴⁴³

M. Balance Owed at Time of Invoice and Account Changes Made After That Date Resulting in an 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.

Note: 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.

⁴⁴³ Refer to Chapter 5 for additional information regarding IRS reconciliation of Advance Premium Tax Credits (APTC).

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.

N. Notification

Individuals who are overdue on their bill will receive a *Late Payment Notice* with their monthly invoice.⁴⁴⁴ 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 Payment Notices* and *Intent to Terminate Notices* are visible in a customer's online account and are sent either by paper mail or via email notification depending on the customer's indicated preference. Employers who are overdue have a two-month grace period,⁴⁴⁵ and will receive an *Intent to Terminate* notice. Employers who continue to be delinquent one-month beyond the overdue date will be terminated for non-payment after two months, in accordance with grace period rules.^{446,447}

Individuals enrolled in a QHP have a three-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 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.

O. Pending and Un-pending Claims During Grace Period Months

In the case of an enrollee who is delinquent in their premium payment, HSRI 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 their 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 may eventually be terminated from coverage in accordance with the dates outlined in [Section E](#) of this Chapter. Health insurance companies retain the right to collect upon unpaid premiums for months

⁴⁴⁴ 45 CFR § 156.270(f)

⁴⁴⁵ R.I. Gen. Laws § 27-18-3(a)(3)

⁴⁴⁶ 45 CFR § 155.430(d)(5)

⁴⁴⁷ R.I. Gen. Laws § 27-18-3(a)(3)

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)

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 un-pended.

Note: Partial payments, such as paying for just one month when two months are past due, will not adjust the grace period months.

P. Automatic Renewal and De Minimis Variations

In the case where a customer has active coverage in a given year, HSRI may notify the customer that the customer is eligible for automatic renewal for the following year. If the customer who has been notified owes less than five dollars (\$5.00) on the payment due date for January coverage in December, including the premium for January of the upcoming year, the customer's coverage may automatically renew for January in the upcoming year. The customer may be liable to pay back any tax credits paid out for the month January, and every other month of coverage where the customer does not pay their full share of the premium.

Note: Customers who have been notified that their coverage will automatically renew for the following year, who owe less than five dollars (\$5.00), and do not 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.

Q. 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 fifteen (15) days after a customer payment has been made.

- Refunds must be requested by phone via the HSRI Contact Center. Mailed requests for refunds will not be reviewed.
- If a customer has active coverage and plans to continue with HSRI, the customer 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 investigate 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 the Rhode Island 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.

1) 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.

R. 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.

S. Collection After Termination

After the coverage of an individual, family, or employer group is terminated, HSRI 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 HSRI, which is due to the issuer, HSRI will forward such amounts to the respective health insurance company.

T. 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 S](#) above, after the coverage of an individual, family, or employer group is terminated, HSRI will cease with collection activities and allow the health insurance company to directly collect amounts due to it. When HSRI is served with any notice pursuant to *Section 362(a) of the Bankruptcy Code*, HSRI may forward the notice and its attendant documents to the health insurance issuer.

Chapter 13: HealthSource RI Account Creation & Maintenance

A. **Application Process Overview**

Customers must complete and submit a HealthSource RI (HSRI) application in order to be eligible to seek coverage through HSRI.

During annual Open Enrollment Periods (OEPs) or during a Special Enrollment Period (SEP), individuals may apply for coverage through HSRI:

- 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 (Visit www.HealthSourceRI.com for HSRI Contact Center hours of operation or to make an appointment)
- By completing and submitting a paper application to: HealthSource RI, 401 Wampanoag Trail, East Providence, RI 02915

For more information about the annual OEP and SEPs, see [Chapter 3](#).

1) **Completing the Application**

Completing the application is the first step in the process of getting coverage. The application helps HSRI determine program eligibility, including whether the applicant may be eligible for:

- Government-sponsored coverage from Rhode Island Medicaid or RItE Care;
- Qualified Health Plans (QHPs);
- 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 an 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 HSRI. In other words, the application process helps HSRI to determine whether an individual is **eligible** to enroll in a QHP 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 HSRI, and the applicant has been determined eligible to enroll in a QHP through HSRI, the applicant may select, enroll in, and pay for a plan. For more information about eligibility to enroll in plan through HSRI, 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 their enrollment will be cancelled, and coverage will not start. The applicant must then resubmit their 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

HSRI 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 HSRI needs more information to determine eligibility for coverage;
- Notification that HSRI has found a discrepancy in data sources and needs more information from customer regarding current eligibility;
- Notification of eligibility for an SEP;
- Notification of enrollment in a QHP;
- Notification that a customer is late in paying a monthly premium;
- Notification of disenrollment from a QHP; and
- Notification regarding the annual OEP.

Any notices required to be sent by HSRI 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 HSRI 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".

Note: Users should ensure e-mail notifications are not filtered into "spam" folders, as these notices are critical communications from HSRI.

Customers may change their communication preference at any time within their HSRI user account in the "Account Info" tab under "Contact Information".

For all HSRI 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 of HSRI for Employers, billing statements are sent via the customer's communication preference. See [Chapter 12](#) for more information about billing and premium payment deadlines.

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.

⁴⁵¹ 45 CFR § 155.230(a)

Note: The customer will not receive any notices or invoices if an Authorized Representative has been selected, though the customer always has access to their 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 HSRI.

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 the representative 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 HSRI Contact 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 HSRI. Customers should inform HSRI 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 ten (10) days,⁴⁵³ while those enrolled in a QHP with or without financial assistance, must report within thirty

⁴⁵² 45 CFR § 155.330(b)(1); 42 CFR § 435.916(c)

⁴⁵³ 42 CFR § 435.916(c)

(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 HSRI and/or the Department of Human Services (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 (IAPs) when the customer applied for coverage (i.e., indicated the enrollee 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 HSRI coverage. For example, a change in address or incarceration status.⁴⁵⁵

F. Applicant Rights & Responsibilities

In accordance with federal and state law and U.S. Department of Health and Human Services (HHS) policy, HSRI 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.

HSRI and the RI Medicaid agency, Rhode Island Executive Office of Health and Human Services (EOHHS) must:

- Help customers fill out all requested forms
- Provide interpreter or translator services at no cost when a customer is communicating with HSRI or EOHHS.

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

⁴⁵⁴ 45 CFR § 155.330(b)(4)

⁴⁵⁵ 45 CFR § 155.330(b)(2)

вора 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 ajujọ gbasara Healthsource RI, I nwere ohere iwenta nye maka na ọmụma na asụsụ gị na akwu gị ụgwọ. I chọrọ I kwurọ onye-ntapịa okwu, kpọ 1-855-840-4774.

Yoruba

Bí iwọ, tàbí ẹnìkẹni tí o n ranlọwọ, bá ní ibeere nípa Healthsource RI, o ní ẹtọ lati rí iranwọ àti ifitónilétí

gbà ní èdè rẹ láìsanwó. Látí bá ongbufo 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, APTCs, CSRs, 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 HSRI and EOHHs, which

⁴⁵⁶ 45 CFR § 155.305; 42 CFR § 435.910

administers Rlte Care (Medicaid), customer rights and responsibilities, and the coverage obtained through HSRI and EOHHS. By filling out the HSRI 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. HSRI also uses SSN information with other federal and state agencies, including the Internal Revenue Service (IRS), 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, the customer 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 HSRI Privacy Policy, which may be made available to you upon request. Contact HSRI to request a copy. This policy is available on our website (www.healthsourceri.com) to review at any time.

5) HSRI 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 QHP Enrollees Only

1) Responsibility to report changes affecting eligibility

Individuals who enroll in a Qualified Health Plan through HSRI and have a change in income must notify HSRI within thirty (30) days of that change. A change in income could change the tax credits or CSRs 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, the customer will qualify for less tax credits. If an individual does not report a change in income, HSRI 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.

2) 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. HSRI Application Policies

Throughout the course of application and enrollment through HSRI, 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 HSRI 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, HSRI 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 HSRI.
- **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 www.healthsourceri.com/application-policies/ for review at any time.

K. Working with Navigators & Certified Application Counselors

Navigators and Certified Application Counselors (CACs) 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 assistance only for individuals and families. HSRI may permit Navigators and CACs to provide assistance virtually or telephonically.

1) Reach out to a Navigator

HSRI has over 100 certified and trained Navigators available for in person assistance by appointment. Search the full list (<https://healthsourceri.com/enrollment-support/>) 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 the HSRI Contact Center for anyone who needs assistance in other languages not offered by existing navigator agencies.

2) Meet with a Certified Application Counselor

The CAC 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 HSRI. CACs may provide in-person or virtual 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 meeting with the customer. The relationship remains at the discretion of the customer, not the CAC.

CACs have volunteered to be trained and certified by HSRI. They are located in agency settings across the state. Review the full list of participating agencies here: ([Rhode Island Health Center Association | Health Center Directory \(rihca.org\)](http://Rhode Island Health Center Association | Health Center Directory (rihca.org))).

For agencies interested in training CACs:

There will be no form of payment from HSRI, or any other entity, to the agency or the CAC for this work. CAC 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 CAC entities should review the application and guidelines available at: [Rhode Island Health Center Association \(rihca.org\)](http://Rhode Island Health Center Association (rihca.org)).

3) Special rules regarding assistance

Navigators are able to assist an individual who needs to follow up on a verification or other task with the HSRI Contact Center over the phone after an in-person or virtual appointment. Both the Navigator and the Customer would need to be on the phone together for the HSRI Contact Center to have permission to assist the customer. This option is not available for CACs.

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 CAC is certified

All Navigators and CACs must display their certificate when working with a customer. Navigators use this certification number to obtain an account with HSRI 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 CACs 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.