EXPERT UPDATE

Compliance Headlines from Henderson Brothers:

- Exchange Coverage Eligibility for Cost Sharing Reductions & Verification of Employer Sponsored Coverage

HENDERSON BROTHERS

Exchange Coverage Eligibility for Cost Sharing Reductions & Verification of Employer Sponsored Coverage

Beginning in 2014, individuals will be entitled to purchase coverage from an Exchange, which is intended to provide a mechanism for organizing the health insurance marketplace to help consumers and businesses shop for coverage. This health insurance market will enable eligible individuals and employers to receive premium tax credits or coverage through Federal or State-based Exchange programs. States must be on track for achieving certification of their State-based Exchange by January 1, 2013, and for those states that are behind in the process or choose not to build a State-based Exchange at all, a Federal Exchange will be established to address this health insurance marketplace requirement.

Starting in 2014, small employers will be permitted to offer coverage to their employees through an Exchange. The regulations define a small employer as an organization that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year, and employs at least one employee on the first day of the plan year. This definition of "small employer" is different than the definition of small employer for the employer pay or play mandate.

Before 2016, a state will have the option to define small employer by substituting 50 for 100 in the standard definition. This results in a corresponding change in the "large employer" definition used by a state adopting the modified small employer definition. Of the states that have enacted legislation to run State-based Exchanges, most have yet to determine the composition of their Exchange. More information will be released as states communicate their position with respect to the definition of small employer for 2014.

Beginning in 2017, states may allow large employers to access coverage through an Exchange. For states that have not adopted the different definition of small employer, this will mean that an employer with 101 or more employees will be able to obtain coverage through an Exchange at this time.

Coverage offered through an Exchange generally will not constitute a qualified benefit under Code § 125 and therefore cannot be offered under a cafeteria plan. However, there is an exception for Exchange-eligible employers that offer their employees the opportunity to enroll through an Exchange in a qualified health plan in a group market. Under these circumstances, employees may pay for such coverage with pre-tax dollars under the employer's cafeteria plan.

Eligibility Determinations

HHS will require that the Exchanges perform eligibility determinations using a system of coordinated eligibility and enrollment so that an individual can simultaneously apply for enrollment in a Qualified Health Plan (QHP) as well as Insurance Affordability Programs (IAPs).

Under HHS regulations, an individual would be eligible for enrollment in a Qualified Exchange Plan if he or she meets the following basic standards –

1) is a citizen, national, or non-citizen lawfully present, and is reasonably expected to remain so for the entire period for which enrollment is sought;

2) is not incarcerated: and

3) resides in the state that established the Exchange.

HHS regulations establish a residency standard based on the "service area" of an Exchange, which accounts for regional or subsidiary Exchanges that serve broader or narrower geographic areas than a single state. For instance, according to the

regulations, an individual aged 21 or older who is not institutionalized, is capable of indicating intent, and is not receiving a state supplementary payment meets the residency standard for enrollment in an Exchange QHP if the applicant intends to reside in the state within the service area of the Exchange through which the individual is requesting coverage.

After an Exchange determines eligibility, the Exchange provides the individual with a timely, written notice of his or her eligibility determination. Even though the Exchange must accept an application and make an eligibility determination for an applicant at any time during a benefit year, this requirement does not supersede the limited enrollment periods described in the regulations. The regulations indicate that Exchanges are required by health care reform to provide an initial open enrollment period, an annual open enrollment period, and certain special enrollment periods.

The Exchange will coordinate determinations of eligibility for a Qualified Health Plan (QHP) with determinations for "insurance affordability programs" (IAP). Individuals who qualify for the IAP will be entitled to receive advance payments of the premium tax credit and cost-sharing reductions, Medicaid, CHIP, or any State-established basic health program.

HHS regulations identify the eligibility parameters for cost-sharing reductions. Eligible participants include –

1) a taxpayer with a household income of at least 100% but not more than 400% of the federal poverty level (FPL) for the benefit year for which coverage is requested, and

2) an applicant's dependents for whom the taxpayer expects to claim a personal exemption deduction on his or her tax return for the benefit year.

Whether the applicant is a taxpayer or an eligible dependent of a taxpayer, as the code is written now, both must be ineligible for minimum essential group coverage in accordance with the regulations. If a proposed safe harbor is passed, employees could still be eligible for premium assistance (or cost sharing reductions) even when the employer offers affordable minimum essential group health plan coverage.

If the Exchange determines that a taxpayer is eligible to receive advance payments of the premium tax credit, the Exchange will then calculate the advance payments in accordance with IRS rules. IRS regulations provide comprehensive rules for determining taxpayer eligibility for the credit, as well as detailed rules for determining eligibility for minimum essential coverage, including employer-sponsored coverage.

In addition, HHS regulations set forth the standards for the Exchange to determine that an individual is eligible for cost-sharing reductions. Among other things, these standards include three eligibility categories for cost-sharing reductions and require the Exchange to determine that an individual is enrolled in a QHP in the silver level of coverage in order to receive the reductions.

Notification to Employer

When the Exchange determines an applicant is eligible to receive advance payments of the premium tax credit or cost-sharing reductions based in part on a finding that his or her employer does not provide minimum essential coverage, or provides coverage that is not affordable, or does not meet the minimum value standard, HHS regulations require the Exchange to notify the employer and identify the employee. Responding to privacy concerns, the preamble explains that HHS believes that only the minimum necessary personally identifiable information should be released to an employer in the notice. The final regulations expand the content requirements, so that notices include the employee's identity, that the employee has been determined eligible for advance payments of the premium tax credit, that the employer may be liable for a shared responsibility payment, and that there is an opportunity to appeal. But HHS does not believe this poses a substantial threat to privacy, noting that details such as the employee's tax return information or the exact reason the employee is eligible for assistance are not expected to be included.

The employer may appeal a determination that an employee of the employer is eligible for advance payments of the premium tax credit or cost-sharing reductions based in part on a finding that the employer did not offer qualifying coverage to the employee. Future guidance on this process is expected.

Verification of Employer-Sponsored Coverage

HHS has issued a bulletin addressing the information-gathering process Exchanges are to follow in making eligibility determinations for individuals applying for coverage. In particular, it requests comments on a proposed interim strategy for the 2014 and 2015 plan years for obtaining information about access to employer-sponsored coverage, which will be relevant for determining eligibility for advance payments of the premium tax credit. Until more comprehensive data sources are available, individuals are expected to request relevant information from employers on a voluntary basis and, as a result, HHS has proposed to develop a standardized way to collect and communicate the necessary employer coverage information. In addition, in the absence of complete information pre-enrollment, Exchanges would be allowed to

verify information based on other available data sources (including state databases) and then apply a post-enrollment screening process, which could require direct contact with employers to verify missing information. HHS has indicated that pre-enrollment verification, when possible, is the preferred approach.

HHS is also considering the development of a long-term verification strategy to foster the identification and deployment of data sources, including leveraging data accumulated through other reporting requirements, and facilitate real-time verification of employer coverage information during the enrollment process.

Additional regulations and guidance should be released shortly.