Covered Clips

A Weekly Summary of News and Activities for the Cover Arizona Coalition[](http://stylegirlfriend.com/wp-content/uploads/2012/04/paper-clips-style-girlfriend.jpg)

Weeks of April 27th and May 4th

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# **CMS Announces Opportunity to Apply for Navigator Grants in Federally-facilitated and State Partnership Marketplaces**

On April 15th; the Centers for Medicare & Medicaid Services (CMS) announced the availability of funding to support Navigators in Federally-facilitated Marketplaces (FFM), including State Partnership Marketplaces. Grantees will be selected for a three year project period, and a total of up to $67 million is available for the first year of the award. The multi-year grant award will be funded in 12-month increments and continued funding will be contingent on the grantee continuing to meet all Navigator program requirements and on funding availability. The funding opportunity announcement is open to eligible individuals, as well as private and public entities, applying to serve as Navigators in states with a FFM.  It is open to new and returning HHS Navigator grant applicants, and applications are due by June 15, 2015.

* To access the funding opportunity announcement, visit: <http://www.grants.gov>, and search for CFDA # 93.332.
* To view the CCIIO website dedicated to In-Person Assistance in the Health Insurance Marketplaces, click here.
* To view the press release that accompanied this announcement, click here.

**In addition, below are key dates for pre-application calls:**

* Wednesday, May 20, 2015 from 11:00am-12:30 p.m. Eastern Time

o   Audience URL: [Click here](https://goto.webcasts.com/starthere.jsp?ei=1061472)

o   Webcast title: Navigator Funding Opportunity Announcement Pre-Application Webinar 5-20-15

* Wednesday, June 3, 2015 from 2:00-3:30 p.m. Eastern Time

o   Audience URL: [Click here](https://goto.webcasts.com/starthere.jsp?ei=1061473)

o   Webcast title: Navigator Funding Opportunity Announcement Pre-Application Webinar 6-3-15

**AHCCCS Patients Can Intervene In Medicaid Expansion Case**

Arizona Capitol Times

Four AHCCCS patients can intervene as defendants in the lawsuit against Arizona’s Medicaid expansion program because they have a direct stake in the outcome and the program’s director may not adequately represent their interests, a Maricopa County judge said.

Superior Court Judge Katherine Cooper ruled on Tuesday that the four childless adults, who receive health care coverage as a direct result of the 2013 expansion program, can intervene as defendants. Both the Arizona Health Care Cost Containment System and the Goldwater Institute, which represents 36 GOP lawmakers who are seeking to overturn the program, opposed the intervention.

The Arizona Center for Law in the Public Interest, a public interest law firm that represents the four patients, argued that AHCCCS Director Tom Betlach may have divided loyalties in the case. He helped craft the program under then-Gov. Jan Brewer, but now serves at the pleasure of Gov. Doug Ducey, who has voiced opposition to Medicaid expansion.

Though Betlach’s attorney and the Goldwater Institute argued that the AHCCCS director would adequately represent the four patients’ interests, Cooper sided with the patients.

“Defendant Director Betlach is now in the position of defending an action taken by his former employer,” Cooper wrote. “And, he oversees a state agency that ‘represents the interests of the state in general, which includes other citizens in the state.’”

Cooper also noted that the patients have a direct interest in the outcome of the case. If the 36 Republican legislators prevail, the patients will lose their AHCCCS coverage.

The lawsuit alleges that the hospital assessment that funds Arizona’s portion of the funding for Medicaid expansion is a tax that should have been subject to a provision in the state Constitution requiring a two-thirds supermajority in the Legislature to pass a tax increase. The Legislature passed the program in 2013 with only a simple majority.

Oral arguments are scheduled in the case for July 17.

http://azcapitoltimes.com/news/2015/05/01/ahcccs-patients-can-intervene-in-medicaid-expansion-case/

**Native American Caucus to Federal Government: Reject Proposed**

**AHCCCS Changes**

The Yellow Sheet

Members of the Arizona State Legislature’s Native American Caucus recently sent a letter to U.S. Health and Human Services Secretary Sylvia Mathews Burwell urging her to deny Arizona’s request for a waiver of certain requirements for the Arizona Health Care Cost Containment System, the state’s Medicaid program. That request was sent pursuant to the recent passage of SB 1092. If the waiver is approved, the state would be allowed to place significant limitations on AHCCCS recipients.

SB 1092 would require that AHCCCS recipients be employed, participating in job training or actively seeking employment, and it would impose a 5-year lifetime enrollment limit on Medicaid benefits. With unemployment rates on Indian reservations at record levels, Native American legislators are concerned that these proposed restrictions would have a devastating impact.

“SB 1092 would put an unbearable stress on Native American communities in Arizona and would represent a continuation of centuries of oppressive treatment of indigenous people,” said Rep. Victoria Steele, D-Tucson (District 9).

Rep. Sally Ann Gonzales, D-Tucson (District 3), added that SB 1092 is also problematic because it sets employment requirements but does not provide any funding for employment resources.

“I strongly oppose SB 1092 because it will harm hundreds of thousands of Arizonans. It provides no money for job training programs, which are desperately needed on Indian nations. And the 5-year limit on benefits does not provide people with long-term healthcare,” Gonzales said. Moreover, SB 1092 will reduce revenue to health care facilities on Indian nations, further harming Native American communities.

“SB 1092 will negatively impact Arizona Native American health care facilities by reducing the amount of revenue they receive. This may result in a decreased quality of care to all Native American children, families and the elderly. All Arizonans should be concerned about this legislation,” said Rep. Jennifer Benally, D-Tuba City (District 7).

Sen. Carlyle Begay, D-Ganado (District 7), agreed that SB 1092 will affect health services and that the consequences of the law would disproportionately burden Native Americans.

“SB 1092 would have enormous consequences for Native Americans, as well as the Indian Health Service and tribal and urban Indian providers from whom many Native Americans receive health services. Placing a lifetime limit on Medicaid eligibility and instituting a work verification requirement disproportionally hurts Native American families,” Begay said. “It would also impair critical preventive measures intended to lessen the effects of chronic stress and social marginalization, which remain serious challenges in Native American communities.”

Rep. Albert Hale, D-St. Michaels (District 7), acknowledged moving people off government assistance and toward self-sufficiency is an admirable goal, but not if the process leaves people without the care they need.

“As legislators, we sometimes fail to see or understand the unintended and often very complex consequences of our actions. We affect the lives of every person in Arizona. SB 1092 is an example of the legislature not acknowledging the many consequences of its actions. Self-sufficiency for all Arizonans is an admirable goal, but when the tools by which people move toward that goal are lacking, we only exacerbate the problems faced by many people in this state. Without job training and economic development programs on Indian nations, the proposed employment requirements for AHCCCS will be impossible for many people to meet. I am hopeful that the federal government will see these unintended consequences and reject Arizona’s request for a waiver and thereby not breach its trust responsibility to Native American people.”

All five members of the Native American Caucus voted against passage of SB 1092.

**ObamaCare Tax Impact Less than Expected: TurboTax**

The Hill

Less than half of taxpayers who got health insurance through the ObamaCare marketplaces had to return part of their tax subsidy to the government, according to data compiled by TurboTax.

The online tax preparer said Wednesday that 44 percent of taxpayers who received an incentive to help pay for insurance owed an average of between $315 and $365. For many taxpayers, that payment might have meant a smaller than expected refund.

The most recent tax filing season, which ended for most taxpayers on or before April 15, was the first in which people who purchased insurance from healthcare exchanges were forced to reconcile how much of a tax credit they received with earlier estimates of their income.

For that reason and others, many tax analysts and practitioners predicted that the IRS would face a rocky filing season. But John Koskinen, the IRS commissioner, has said the filing season went "swimmingly," even as he bemoaned the agency's dwindling budget and its poor customer service record.

TurboTax added in its Wednesday release that roughly a third of taxpayers who got insurance through the Affordable Care Act marketplaces got money back from the government, because they underestimated their income for last year. The average refund for those taxpayers, TurboTax said, was between $207 and $257.

TurboTax's figures illustrate just how tough it has been to nail down how the ACA incentives for insurance affected taxpayers this filing season. Most taxpayers didn't receive the tax credit for insurance.

H&R Block said this week that roughly two of three taxpayers who got insurance through the exchanges owed the government money, at an average cost of $729. Koskinen himself has said that around 55 percent of taxpayers ended up getting smaller refunds, though more definitive statistics from the IRS have yet to be released.

**Only a Fraction of Eligible Enrollees Took Advantage of Special Enrollment Period**Politico Pro

The second chance to sign up for 2015 Obamacare coverage ends in most states today — but it doesn’t appear that the special enrollment period for those penalized by the law’s individual mandate will significantly boost 2015 sign-up numbers. Only a fraction of those eligible for this special enrollment period have sought coverage, according to the latest available numbers. Just 68,000 people in the 34 states with federal-run exchanges had signed up as of April 13, HHS said. Another 91,000 consumers in California had enrolled as of April 28, according to state officials. And in Washington State, 16,000 people signed up in the month long special enrollment period that ended two weeks ago. The numbers could increase with a surge of last-minute sign-ups tonight, and a final enrollment tally likely won’t be released for some time. Still, the numbers so far indicate that the individual mandate penalty might be too low to coerce people into getting coverage. HHS announced earlier this year it would allow a special enrollment period for uninsured people who learned for the first time that they would have been penalized for not having coverage. The administration had estimated up to 6 million people would have to pay the penalty this year. The fine for skipping coverage in 2014 was $95 per person or 1 percent of household income, whichever is greater. The fine increases this year to $325 per person or 2 percent of household income. Those penalties might not be strong enough to encourage most people to enroll, according to an analysis released earlier this week from the Avalere Health consulting firm. Avalere noted that premiums are much higher than the fines for many potential exchange consumers. Just those with incomes near the federal poverty level, or about $11,770 for an individual, and some earning up to double that would save money by getting health insurance instead of paying the fine, according to the report.

**US to Set Tougher Standards for Companies Running Medicaid**

Washington Post

Lynda Douglas thought she had a deal with Tennessee. She would adopt and love a tiny, unwanted, profoundly disabled girl named Charla. The private insurance companies that run Tennessee’s Medicaid program would cover Charla’s health care.

Douglas doesn’t think the state and its contractors have held up their end. In recent years, she says, she has fought to secure essential care for Charla.

“If you have special-needs children, you would not want to be taking care of these children and be harassed like this,” Douglas said. “This is not right.”

Across the country, state Medicaid programs, which operate with large federal contributions, have outsourced most of their care management to insurance companies like the ones in Tennessee. The companies cover poor and disabled Medicaid members in return for fixed payments from taxpayers.

That helps government budgets but sets up a potential conflict of interest: The less care these companies deliver, the more money they make. Nationwide, such firms had operating profits of $2.4 billion last year, according to regulatory data compiled by Mark Farrah Associates and analyzed by Kaiser Health News.

In an attempt to manage that tension, Washington regulators are about to initiate the [biggest overhaul of Medicaid managed-care rules](https://urldefense.proofpoint.com/v2/url?u=http-3A__kff.org_medicaid_issue-2Dbrief_awaiting-2Dnew-2Dmedicaid-2Dmanaged-2Dcare-2Drules-2Dkey-2Dissues-2Dto-2Dwatch_&d=BQMFAg&c=RAhzPLrCAq19eJdrcQiUVEwFYoMRqGDAXQ_puw5tYjg&r=Kc0Xlu3v3pKVhcrFmB4M5KkDkelMUBvvXqaHazCQe0Y&m=F0coot-3pVNiem4eKc8NB7xwo0KcRc1vsJzw_8DiT4g&s=z_-w4qyciWIBXQqS_6lepbOjUeNcucWvoIq3SWHOA1c&e=) in a decade. Prompted by the growth of Medicaid outsourcing and concerns about access to care, the regulations are expected to limit profits and set stricter requirements for quality of care and the size of doctor networks.

“We want the enrollees to have timely access to integrated, high-quality care,” James Golden, who oversees Medicaid managed care for the Department of Health and Human Services, told a group of insurance executives in February.

Tennessee Medicaid contractors — operated by BlueCross BlueShield of Tennessee, UnitedHealthcare and Anthem — [are among the most profitable](http://us.milliman.com/insight/research/health/Medicaid-risk-based-managed-care-Analysis-of-financial-results-for-2011/) Medicaid plans in the country, according to data from Milliman, a consulting firm.

State officials point to data on quality and survey results as evidence that the companies are doing a good job while allowing the state to spend far less on Medicaid than predicted. In a survey last year, more than [90 percent of customers](http://cber.bus.utk.edu/tncare/tncare14.pdf) using TennCare, as the program is known, said they were very satisfied or somewhat satisfied, officials note.

TennCare Director Darin Gordon worries that new federal rules could hinder states from improving Medicaid quality while controlling costs. “Don’t hamstring us,” he said.

http://www.washingtonpost.com/business/economy/us-to-set-tougher-standards-for-companies-running-medicaid/2015/04/27/fb129388-ecee-11e4-a55f-38924fca94f9\_story.html?utm\_campaign=2015-04-28%20Stateline%20Daily.html&utm\_medium=email&utm\_source=Eloqua

**Insurers Ignoring Birth Control Requirements**

The Hill

Insurance companies are widely ignoring an ObamaCare rule that requires them to provide free or low-cost birth control, according to a report by the National Women’s Law Center.

Some insurance companies are still charging women out-of-pocket costs for birth control and limiting their coverage to only certain methods of birth control, both violations of the Affordable Care Act, according to the 22-page report to be released Wednesday.

"Unfortunately, not every woman who should be getting coverage of her birth control without out-of-pocket costs has been able to access this important benefit," states the report, which is based on an analysis of 100 plans in 15 states.

The most common coverage problems are for the vaginal ring, the patch and an intrauterine device (IUD). In some cases, the insurance company will "even suggest that a woman switch methods if she does not want any out-of-pocket costs," according to the report.

Some companies are not covering the costs of related doctor’s appointments or are imposing age limits on coverage.

The uneven levels of coverage "not only fail to comply with the [Affordable Care Act], but recreate the cost barriers that existed prior to the ACA that contribute to increased risk of unintended pregnancy," the group wrote.

The organization believes that the violations are widespread beyond its sample 15 states. Women living in all 50 states have told the organization’s birth control information hotline that they ran into issues obtaining birth control on their insurance plan.

The National Women’s Law Center will announce its findings Wednesday at a press conference joined by Sen. Patty Murray (Wash.), a top Democrat on the Senate’s Health, Education, Labor and Pensions Committee.

Murray [already sent](http://thehill.com/policy/healthcare/240355-murray-calls-on-insurers-to-obey-obamacare-contraceptive-rule) letters to eight health insurance companies in her home state on Tuesday, raising concerns about the lack of compliance on the rule after other reports made similar findings.

The National Women’s Law Center is now urging the federal government to further clarify its rules on ObamaCare by issuing more guidance to insurance companies and to states.

The organization is also calling on state and federal agencies to more closely evaluate insurance companies’ plans and to better manage consumer complaints.

A spokeswoman for the Department of Health and Human Services quickly reiterated that the office takes "reports of non-compliance very seriously."

"We will continue to provide guidance to help ensure that women have access to recommended preventive benefits and will explore whether additional measures are necessary," spokeswoman Katie Hill wrote in an email.

The head of America's Health Insurance Plans, an insurers' group, blasted the study for presenting "distorted picture of reality."

"To use highly selective anecdotes to draw sweeping conclusions about consumers’ coverage does nothing to improve the quality, accessibility, or affordability of health care for individuals and families,” the group's president and CEO, Karen Ignagni, wrote in a statement.

**Income-Base ‘Churn’ in Coverage Less Common than Feared**

Policy experts worried lower-income people would get bumped back and forth between Medicaid and exchange plans under the Affordable Care Act. A Modern Healthcare survey of exchanges and insurers suggests such disruption has been minimal so far.   
  
When this so-called churning has occurred, health plans and providers have found ways to mitigate the impact on patients' continuity of care, health plan officials say. But much remains unclear about what happens to this population as it shifts between different types of coverage.  
  
Churning is what happens when people move between private coverage and Medicaid or else become uninsured. People may churn between private coverage, Medicaid and no insurance due to job loss, reduction of work hours, employers deciding to offer coverage, or other life change circumstances.  
  
A 2011 Health Affairs analysis estimated that more than 35% of all adults with incomes below 200% of the federal poverty level would experience a shift from Medicaid to an exchange plan within six months, or the reverse, and that 50% would experience a shift within a year. Matthew Buettgens of the Urban Institute has estimated that 7 million people could churn between Medicaid and exchange plans each year.  
  
Experts say churn can be disruptive to people's continuity of benefits and healthcare, particularly if they have medical conditions for which they are receiving treatment. In addition, it can be harder for people to access healthcare providers, particularly specialists, if they switch to Medicaid, which often pays lower rates.   
  
“For a patient under a physician's care for a condition like cancer or renal failure, changing providers in the midst of chemotherapy or dialysis can be incredibly disruptive,” said Chris Stenrud, executive director of government relations at Kaiser Permanente.  
  
But 14 months since the ACA coverage expansions were implemented, churn is happening at a relatively low rate, according to data from state exchanges, researcher insight and anecdotal feedback from payers. “There was this huge fear about churn, but I haven't been hearing much about it,” said Katherine Hempstead, a health insurance policy director at the Robert Wood Johnson Foundation.  
  
Since January 2014, more than 118,000 people—or about 8% of those who signed up for private plans on California's exchange—exited a private plan and enrolled in Medi-Cal, state officials say. In New York, about 27,000 people—about 7%—of the people who signed up for private exchange coverage had an income change that made them eligible for Medicaid, though state officials have not tracked whether they actually signed up for Medicaid.   
  
In Massachusetts, 13%, or 4,000 people, went from an exchange plan to Medicaid. The figure was 6% in Washington state, 5.5% in Rhode Island, 7.6% in Connecticut and fewer than 2% in Hawaii. Other state-run exchanges either declined to release data on the number of people moving between private plans and Medicaid, or they said they did not have data on churning.  
  
A CMS spokesman said no data on churning between private plans and Medicaid were available for the nearly three dozen states using the federal marketplace. But a committee of health plans selling products on the federal exchange that has been tracking the trend has noted a small but steady exodus from exchange plans. The committee, however, could not determine whether the people exiting the exchange plans were transitioned to Medicaid or employer coverage or became uninsured.  
  
Don Petry, program manager for healthcare reform at Blue Cross and Blue Shield of Tennessee and a member of that committee, said health plans on the federal exchange are collectively losing 3% to 5% of enrollees each month due to nonpayment.  
  
Insurers say they lack a basis for comparison for whether the churn rate so far under the ACA is high, low or typical. “There aren't statistics to base it on, this is all brand new,” Petry said. “In the commercial market people usually sign up and are in for a long period, so there is no apples-to-apples comparison.”  
  
Taylor Burke, an associate professor in health policy at George Washington University, said, “We are still learning what churn looks like in the new ACA world.” Burke said the fact that there are 25% more insurers on the federal exchange for 2015 compared with 2014 shows insurers are not particularly worried about the churn rate. “They are not running away from the exchanges,” he said.  
  
To mitigate the effect of churn and maintain continuity of coverage and care, some insurers including Kaiser Permanente and Molina Healthcare, are offering both Medicaid plans and exchange plans. That enables enrollees to transition more seamlessly between commercial and Medicaid coverage. “Our Medicaid members have access to the same physicians and services as all other Kaiser Permanente members, so the care that our members receive does not change,” Kaiser's Stenrud said.  
  
Provider-owned plans, such as MetroPlus in New York City, say they make it easier for members to move between exchange coverage and Medicaid because enrollees can stay with their network. “Our providers generally accept all products so people have the continued ability to see a doctor,” said Seth Diamond, chief operating officer of MetroPlus Health Plan, which is owned by the New York City Health and Hospitals Corp.  
  
There are some reports from state-run exchanges that they face technology problems when people experience an income change making them eligible for Medicaid and then end up simultaneously enrolled in an exchange plan and Medicaid, said Dan Mendelson, CEO of consulting firm Avalere Health. These mix-ups have led to people being uninsured until the problem got resolved. “These problems have caused some people to be dis-enrolled,” he said.  
  
Barbara Morales Burke, vice president of health policy at Blue Cross and Blue Shield of North Carolina, said “we don't receive information about why people drop coverage, so we have no ability to gauge how many lose coverage due to income.”  
  
Insurance leaders in New York hope that their state's move to implement a Basic Health Program under the ACA in 2016, which would cover most non-elderly adults with incomes between 139% and 200% of the federal poverty level in a single seamless program, will improve continuity of coverage and care for lower-income people.  
  
Lindsay Nelson, coordinator of community development and outreach at the Kentucky Primary Care Association, said healthcare providers are finding ways to maintain continuity of care for their patients when they churn between exchange and Medicaid coverage. But that may not happen in the 21 states that have not expanded Medicaid to lower-income adults, leaving people with incomes below 100% of the poverty level in the so-called coverage gap.  
  
“Typically if an applicant is switching from (an exchange plan) to Medicaid, they are able to remain with their current providers,” Nelson said. “We have found that most of the Medicaid providers also accept (exchange) plans in the area. If not every provider is in someone's network, we can find a plan that includes the applicant's priority provider.”

<http://www.modernhealthcare.com/article/20150422/NEWS/150429959/income-based-churn-in-coverage-less-common-than-feared>

**Paying Medicaid Clients to Lose Weight, Quit Smoking**

Kaiser Health News

When Bruce Hodgins went to the doctor for a checkup in Sioux City, Iowa, he was asked to complete a lengthy survey to gauge his health risks. In return for filling it out, he saved a $10 monthly premium for his Medicaid coverage. In Las Cruces, N.M., Isabel Juarez had her eyes tested, her teeth cleaned and recorded how many steps she walked. In exchange, she received a $100 gift card from Medicaid to help her buy health care products including mouthwash, vitamins, soap and toothpaste. Taking a cue from workplace wellness programs in the private sector, Iowa and New Mexico are among more than a dozen states offering incentives to Medicaid beneficiaries to get them to make healthier decisions -- and potentially save money for the state-federal health insurance program for the poor. The stakes are huge because Medicaid enrollees are more likely to engage in unhealthy practices, such as smoking, and are less likely to get preventive care, studies show. For years, private employers and insurers have used incentives to spur employees and members to quit smoking, lose weight and get prenatal care, although the record of those programs for changing long-term behavior is mixed. ‘Financial incentives are effective at improving healthy behaviors, though the effect of incentives may decrease over time,’ said a report last year by the Center for Health Care Strategies, a research group based in Hamilton, N.J. The Affordable Care Act is behind the latest push of wellness incentives in Medicaid. Besides Iowa and New Mexico, several other states that have expanded Medicaid have incorporated such incentives, including Indiana, Pennsylvania, New Hampshire and Michigan. Montana, which is about to become the 29th state to extend Medicaid, also plans to include such incentives. ‘People are looking for some creative ways to pass Medicaid expansion and incentivizing healthy behaviors is pretty palatable to both conservatives and liberals,’ said Maia Crawford, program officer of the Center for Health Care Strategies.

http://www.usatoday.com/story/news/2015/05/04/kaiser-paying-medicaid-enrollees-to-lose-weight-quit-smoking/26652255/

**Make Some Noise for Affordable Care!**

The Community Catalyst Action Fund is continuing to spread the word about the importance of the ACA through telling Julie Adams’ story. Join in the CCAF’s Thunderclap to spread the word here: <http://bit.ly/1F7Jvcp>

Tweet: Support @CCActionFund’s @ThunderClapIt to spread the word about importance of affordable care <http://bit.ly/1F7Jvcp> #KeepAmericaCovered

**Assister FAQs**

CMS

Q: How will getting married in the middle of the year affect consumers’ APTC?

A: Consumers who were married during the coverage year should consult Part 5—Alternative Calculation for Year of Marriage on page 15 of the [Instructions for Form 8962](http://www.irs.gov/pub/irs-pdf/i8962.pdf).

Q: Can a consumer get an SEP to switch plans if the consumer’s provider was mistakenly listed in the plan’s directory as in-network when the consumer enrolled?

A: No. Consumers cannot get an SEP if their provider was mistakenly listed in the plan’s provider directory as “in-network.” Consumers are strongly encouraged to verify with both the insurance company and the provider to confirm the provider’s status. Note that plans use various terms to describe the providers that have a contract with the insurance company to provide services at a discount. Examples include “in-network,” “participating,” or “preferred.” If a provider is incorrectly listed in the plan’s provider directory, consumers should report this error to their state regulatory agency, usually the state department of insurance.

Q: Are there resources available to help consumers estimate their income before they apply, to get a sense of whether they may qualify for financial assistance to purchase a plan?

A: When consumers fill out a Marketplace application, they answer detailed questions about their income and the members of their household. The Marketplace uses consumers’ answers to these questions to determine what programs and savings they qualify for based on their [“modified adjusted gross income,” or MAGI](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&126&&&https://www.healthcare.gov/glossary/modified-adjusted-gross-income-magi/). It is important to remember that consumers should simply answer the application questions, and allow the Marketplace to determine their eligibility based on their answers.

Consumers can only find out their actual eligibility for programs when they submit a Marketplace application. However, it may be useful for consumers to make a ballpark estimate of their income before they apply to see if they may qualify for savings. [HealthCare.gov has new information that will help them to do this](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&127&&&https://www.healthcare.gov/income-and-household-information/). Consumers can use their estimated MAGI whenever a tool on HealthCare.gov asks for their estimated income for the year, though it is important to remember that they will not use this estimate anywhere in the Marketplace application itself, and that consumers can only find out their actual eligibility for programs when they submit a Marketplace application.

Q: What is modified adjusted gross income (MAGI)?

A: Modified adjusted gross income, or MAGI, is the figure used to determine consumers’ eligibility for lower costs in the Marketplace and for Medicaid and CHIP. Generally, MAGI is a consumer’s adjusted gross income plus any tax-exempt Social Security, tax-exempt interest, or tax-exempt foreign income they have. A consumer’s [AGI](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&128&&&http://www.irs.gov/uac/Definition-of-Adjusted-Gross-Income) includes all income minus certain deductions. You can find more information on what income is included for the Marketplace [here](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&129&&&https://www.healthcare.gov/income-and-household-information/income/).

**Tax Penalty SEP Q&A**

CMS

Q. In general, special enrollment periods granted to consumers allow them to take up to 60 days to obtain coverage. Will the Tax Penalty SEP work differently?

A: Yes. Unlike some other special enrollment periods (SEPs), the Tax Penalty SEP is only available to consumers between March 15, 2015 and April 30, 2015.  Eligible consumers wishing to enroll pursuant to this SEP must complete the full enrollment process, including plan selection, by 11:59 pm EDT on April 30, 2015.

Q: If people got an exemption from the fee in 2014, even though they are uninsured, could they take advantage of this special enrollment period? Or, is it only for people who owed a fee for 2014?

A: The Tax Penalty SEP is only for consumers who owe the fee or “individual shared responsibility payment” ($95 or 1% of income, whichever is greater) for at least one month in 2014. Consumers who did not owe the fee at any point during 2014, either because they had minimum essential coverage (MEC) or because they were exempt from the fee for the entire year, are not eligible for this SEP. (Also see the answer to question 6.) To be eligible for this SEP, consumers must also attest that they were unaware of or did not understand the impact of Affordable Care Act requirement to maintain Minimum Essential Coverage (MEC) and not have enrolled in coverage on the Marketplace or other MEC for 2015.

Q: Can agents and brokers assist consumers with enrollment through the Tax Penalty SEP from March 15 - April 30, or can consumers only get enrolled through this SEP by going to the website on their own or by getting help from assisters or the Call Center?

A: The Tax Penalty SEP is available to consumers via questions on the online application. Consumers may access the SEP online at HealthCare.gov or by calling the Marketplace Call Center. Consumers may also seek the help of assisters, agents, or brokers with completing their online application and accessing this SEP.

Q: Will consumers who take advantage of this SEP still have to pay part of the penalty for months they were not covered in 2015, or will there be a waiver for them?

A: The Tax Penalty SEP offers eligible individuals the opportunity to enroll in health coverage through the Marketplace and to reduce their individual shared responsibility payment or “fee” that they will owe for 2015. However, consumers will owe the fee for the months in 2015 that they are without MEC or an exemption. Consumers can visit HealthCare.gov or IRS.gov for information about exemptions for which they may qualify.  By enrolling in coverage through this SEP, consumers will have reduced their shared responsibility payment liability for 2015 and moving forward.

Q: If someone qualifies for an exemption for part of the year, but also owes a penalty for part of the year, is this person eligible for the tax penalty SEP?

A: Yes, as long as they meet the other requirements for this SEP. In order to qualify for the Tax Penalty SEP, consumers must owe the individual shared responsibility requirement or “fee” on their 2014 taxes, must attest that they were unaware of or didn’t understand how the requirement would affect them or their households, and are not currently enrolled in coverage on the Marketplace or other MEC for 2015.

Q: Can a consumer who qualifies for an exemption from 2014 coverage choose to pay the fee and qualify for the Tax Penalty SEP?

A: If a consumer has applied for a full exemption or has received a full exemption from payment of the shared responsibility payment for 2014, he or she is not eligible for the Tax Penalty SEP.

Q: What if a consumer legitimately takes advantage of the Tax Penalty SEP and learns later that he or she was eligible for an exemption for the months that he/she did not have coverage? If this consumer files an amended tax return and claims the exemption, would this cause the consumer to be retroactively terminated from the plan he or she selected with the SEP?

A: No. If the consumer answers the Marketplace application questions about eligibility for the tax SEP truthfully and enrolls in coverage, and later learns that he or she was eligible for a full year exemption for 2014 and claims that exemption, the consumer will not be terminated from the plan he or she has enrolled in through the Tax Penalty SEP. If the consumer learns that he or she is eligible for a partial year exemption, but owes the fee for at least one month, the consumer is still eligible for the tax penalty SEP.

Q: A consumer had minimum essential coverage through her husband’s employer from January 1 through August 31, 2014, but after a divorce in August 2014 has not been enrolled in minimum essential coverage.   Does she qualify for the Tax Penalty SEP?

A: Maybe. To qualify for this SEP, a consumer must owe the individual shared responsibility payment, or “fee,” for being without minimum essential coverage (MEC) for one or more months in 2014.  If a consumer did not receive an exemption for those months in 2014 during which he or she was not enrolled in MEC (i.e. he or she owes the fee for those months) and he or she meets all other requirements of the Tax Penalty SEP, the consumer can qualify for this SEP.  It is important to note that a consumer who loses his or her MEC for any reason should come to the Marketplace either 60 days before or 60 days after the loss of MEC to apply for a “loss of MEC” SEP, which gives an accelerated coverage effective date.

Q: A consumer had minimum essential coverage through her husband’s employer through 2014. She got divorced on January 1, 2015 and she is no longer on his plan. Can she qualify for the Tax Penalty SEP?

A: No. To qualify for this SEP, an individual must owe the fee for being without minimum essential coverage (MEC) for one or more months in 2014. Since the consumer had minimum essential coverage (MEC) for all of 2014, she does not qualify for the Tax Penalty SEP.  As above, the consumer can come to the Marketplace either 60 days before or 60 days after the loss of MEC to apply for a “loss of MEC” SEP.

Q: A consumer owes the fee for being without minimum essential coverage for one or more months in 2014. However, he or she may decide to apply for an exemption for any 2015 shared responsibility payment owed. Can the consumer still qualify for the Tax Penalty SEP?

A: If the consumer owes the fee for 2014 and has not yet applied for an exemption, he or she may qualify for the Tax Penalty SEP, assuming the consumer meets all other requirements for the SEP.

Q. What if a consumer has heard of the requirement to have minimum essential coverage, but he or she assumed they would be exempt because health insurance is so expensive.  When the consumer did their taxes after February 15, 2015, they learned that financial assistance may have been available to make coverage more affordable.  Does the consumer qualify for the Tax Penalty SEP?

A: Maybe.  If the consumer did not understand the meaning or impact of the ACA MEC requirement, and he or she meets the other requirements of this SEP, including owing the fee for being without MEC for one or more months in 2014 and not yet being enrolled in MEC for 2015, he or she may qualify for the Tax Penalty SEP.

**IRS Alternative Calculation to Marriage**

CMS

Consumers who are single when they sign up for Marketplace coverage, are eligible and receive advanced payments of the premium tax credit (APTC), and who may have a change in household size and income because they marry during the tax year that they have signed up for coverage, may have questions about how to reconcile the APTC they received prior to their marriage when they file their new joint tax return.

Q:  Is there an alternative calculation for consumers who applied for Marketplace coverage when they were single, but who married during the year and therefore end up filing taxes jointly with their new spouse, to reduce excess APTC these consumers may have received and must repay?

A:  Yes.  Consumers can elect an alternative calculation for year of marriage in Part 5 of [IRS Form 8962 (Premium Tax Credit)](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&119&&&http://www.irs.gov/pub/irs-pdf/f8962.pdf) when filing their 2014 tax return.  Electing the alternative calculation is optional, but may reduce the amount of excess APTC these consumers must repay with their 2014 taxes.  Consumers can learn more about the calculation and their eligibility for this election, in Part 5 of the [2014 instructions for Form 8962](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&120&&&http://www.irs.gov/pub/irs-pdf/i8962.pdf) and in [IRS Publication 974](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&121&&&http://www.irs.gov/pub/irs-pdf/p974.pdf).

For expert help in understanding and electing this alternative calculation, consumers should [contact the IRS](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&122&&&http://www.irs.gov/Affordable-Care-Act) or seek help from a [qualified tax professional](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&123&&&http://irs.treasury.gov/rpo/rpo.jsf)/ [Volunteer Income Tax Assistance (VITA) site](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&124&&&http://www.irs.gov/Individuals/Find-a-Location-for-Free-Tax-Prep).  Assisters can point consumers to the instructions on Form 8962 for more information if they are in this situation.

**Exemptions Explainer Webinar Summary, Q&A, and Resources**

CMS

Last week, during the Friday, March 27 assister webinar, our series highlighting several specific exemptions continued with a presentation on the [Medicaid gap exemption](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&130&&&https://www.healthcare.gov/exemptions-tool/#/results/details/secretary-hardship).

Consumers qualify for the Medicaid gap exemption from the shared responsibility payment if both of the following applied to them in 2014:

* They lived in a state that didn’t expand its Medicaid program under the Affordable Care Act
* Their income and household size and citizenship or immigration status would have qualified them or their family for Medicaid if the state had expanded coverage

What assisters need to know about this exemption:

* To qualify for this exemption, consumers must have lived in one of these states at any time in 2014: Alabama, Alaska, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maine, Michigan, Missouri, Mississippi, Montana, North Carolina, Nebraska, New Hampshire, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wyoming, or Wisconsin.
* Consumers’ yearly income for 2014 must have been below 138% of the federal poverty level. In most U.S. states, that’s about $16,100 for an individual, $21,700 for a couple, or $32,900 for a family of 4.
* See the [instructions for Form 8962 (PDF)](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&131&&&http://www.irs.gov/pub/irs-pdf/i8962.pdf), pages 4 and 5, for federal poverty levels for the 48 contiguous states, Alaska, and Hawaii.

For 2014, this exemption can be claimed either through a consumer’s federal tax return or through the Marketplace:

* Option 1: Claim on federal tax return: Consumers claiming the Medicaid gap exemption on their federal tax return for 2014 *do not need to have applied for Medicaid in 2014 or received a Medicaid denial.* In November 2014, [CMS](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&132&&&http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Hardship-Exemption-Guidance-11-21-14-final.pdf) and [IRS](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&133&&&http://www.irs.gov/pub/irs-drop/n-14-76.pdf) issued guidance extending this exemption to consumers whose annual 2014 income was below 138% FPL and resided in a state that did not expand Medicaid, without requiring these consumers to have received a Medicaid denial.
* Option 2: Apply through the Marketplace: Consumers who received their Medicaid denial directly from their state Medicaid agency can apply for the exemption through the Marketplace by submitting a paper application for a [hardship exemption](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&134&&&https://marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf) along with a copy of their Medicaid denial. If they are granted the exemption, these consumers will also receive an ECN from the Marketplace. Consumers should input their ECN on [Form 8965](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&135&&&http://www.irs.gov/pub/irs-access/f8965_accessible.pdf) when they file their federal tax return.
* If a consumer already has an Exemption Certificate Number from the Marketplace, they will need to provide it on IRS Form 8965 as part of their 2014 federal tax return.

Additional Resources

* [Presentation slides from “Exemptions from the Individual Shared Responsibility Payment” January 16, 2015 assister webinar](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&136&&&https://marketplace.cms.gov/technical-assistance-resources/exemption-from-shared-responsibility.pdf)
* [Presentation slides from “Exemptions Screener Tool” March 6, 2015 assister webinar](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&137&&&https://marketplace.cms.gov/technical-assistance-resources/training-materials/exemptions-screener.pptx)
* [Exemptions screener tool](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&138&&&https://www.healthcare.gov/exemptions-tool/)
* [IRS coverage exemptions table](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&139&&&http://www.irs.gov/pub/irs-prior/i8965--2014.pdf) (scroll to page 2)
* [HealthCare.gov exemptions](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&140&&&https://www.healthcare.gov/fees-exemptions/exemptions-from-the-fee/) [content](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&141&&&https://www.healthcare.gov/fees-exemptions/exemptions-from-the-fee/)
* [IRS Guidance on Coverage Exemption for Residents of a State that Did Not Expand Medicaid](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&142&&&http://www.irs.gov/uac/RDA-2015-02-09-2014-Instructions-for-Form-8965)
* [Helping Consumers Enroll in Special Enrollment Periods for “Limited Circumstances” through the Health Insurance](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&143&&&https://marketplace.cms.gov/technical-assistance-resources/seps-for-limited-circumstances.pdf) [Marketplace](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&144&&&https://marketplace.cms.gov/technical-assistance-resources/seps-for-limited-circumstances.pdf)

**Assister Q&A from “Exemption Explainer on Medicaid Exemption”**

CMS

Q: Does a consumer need to have been denied Medicaid to qualify for the exemption for residents of a state that did not expand Medicaid?

A: No. Consumers can obtain the Medicaid gap exemption for 2014 without having a Medicaid denial by claiming this exemption on their federal tax return. To qualify, a consumer’s household’s income for 2014 must be below 138% of the federal poverty level, and the consumer must have lived in a state that did not expand Medicaid. An individual or household claiming this exemption on their tax return does not need have applied for Medicaid or to have been denied Medicaid.

Q: Will consumers be able to claim this exemption on their tax returns without a Medicaid denial next year as well?

A: Currently this exemption is only available through the federal tax return (IRS) for 2014.  Consumers who anticipate applying for this exemption for 2015 should submit an application for coverage this year through the Marketplace or their state’s Medicaid agency to ensure that they’ve received a Medicaid denial if they are not eligible because their state did not expand.

Q: What if a consumer was denied Medicaid because their state did not expand, but then she experienced a change in income making her annual income above 138% FPL? Can she still claim the exemption on her tax return?

A: No. Consumers can only claim this exemption on their tax return if their annual household income is below 138% FPL. Consumers who were denied Medicaid and then experienced a change in income putting their yearly income above 138% FPL must apply for this exemption through the Marketplace and submit their Medicaid denial along with the hardship exemption application. Pro tip: Remember that consumers in this situation are eligible for an SEP to enroll in coverage through the Marketplace pursuant to guidance available [here](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&145&&&https://marketplace.cms.gov/technical-assistance-resources/seps-for-limited-circumstances.pdf).

Q: Is the Medicaid gap exemption for the entire coverage year, or only for the portion of the coverage year when the consumer’s income is below 138% of the federal poverty level?

A: The Medicaid gap exemption will be granted for the whole calendar year (e.g. January 2014 through December 2014). Consumers who experience a change in income or other life change affecting their eligibility for Medicaid or financial assistance through the Marketplace should report this change to the Marketplace. However, the Marketplace will not revoke a Medicaid gap exemption that had already been granted due to a change in income. The only case in which a mid-year change in income could affect a consumer’s eligibility for the Medicaid gap exemption is if a consumer did not receive a Medicaid denial during the coverage year (and therefore cannot apply for the Medicaid exemption through the Marketplace), and the change in income caused her annual household income for the coverage year to be above 138% FPL, preventing her from claiming the Medicaid gap exemption on her tax return.

Q: The [results page from the exemptions screener tool](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&146&&&https://www.healthcare.gov/exemptions-tool/#/results/details/secretary-hardship) on the Medicaid gap exemption says that the only way to know if you qualify for this exemption is to complete your 2014 federal income tax return and determine your 2014 income. But that’s not true for consumers who were granted the exemption by the Marketplace, right?

A: Right. The Medicaid gap exemption granted by the Marketplace is slightly different because it requires a consumer to have been denied Medicaid, and for many consumers it was granted in 2014 before they would have completed their 2014 tax return. For consumers who did not receive an ECN from the Marketplace granting this exemption and wish to claim it on their tax return, they must complete their tax and determine their 2014 income to know if they will qualify. If a consumer already has an ECN, they should complete [IRS Form 8965](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&147&&&http://www.irs.gov/pub/irs-access/f8965_accessible.pdfhttp:/www.irs.gov/pub/irs-access/f8965_accessible.pdf) with their ECN as part of their federal tax return filing.

Q: If a consumer lives in a state that expanded Medicaid mid-year such as Michigan and New Hampshire, can consumers in these states still file for an exemption based on ineligibility for Medicaid in a non-expansion state? Would the exemption apply for the full year or only for the months prior to when the state expanded Medicaid? *(Note this Q and A was also included in the March 17, 2015 newsletter)*

A: Consumers who live in a state that expanded Medicaid mid-year in 2014 can still receive an exemption for the full year. Consumers in these states may claim the exemption for the full year on their tax return if their 2014 household income was below 138% of the federal poverty line. Note that this exemption through the IRS does not require proof of Medicaid denial. The guidance can be found [here](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&148&&&http://www.irs.gov/uac/RDA-2015-02-09-2014-Instructions-for-Form-8965).

**Eligibility for non-citizens in Medicaid and CHIP webinar summary and Q&A**

CMS

Immigrants who are “qualified non-citizens” are generally eligible for coverage through Medicaid and the Children’s Health Insurance Program CHIP, if they meet their state’s income and state residency rules.  [Find out more about what the term “qualified non-citizen” includes](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&149&&&https://www.healthcare.gov/immigrants/lawfully-present-immigrants/). In order to get Medicaid and CHIP coverage, many qualified non-citizens, (such as many Lawful Permanent Residents (LPRs) or green card holders) have a 5-year waiting period.  This means they must wait 5 years after receiving their “qualified” immigration status before they can get Medicaid or CHIP. Certain populations are exempt from this 5-year waiting period (such as refugees, or asylees, or LPRs who used to be refugees or asylees).

States have the option to remove the 5-year waiting period and cover lawfully residing children and/or pregnant women in Medicaid or CHIP. A child or pregnant woman is “lawfully residing” if they’re “lawfully present,” and otherwise eligible for Medicaid or CHIP in the state. [To find out more about how an individual is defined as “lawfully present” click here](file:///C:\Users\A48B\AppData\Local\Microsoft\Windows\Temporary%20Internet%20Files\Content.Outlook\4IXG8HOG\%3f%20https:\www.healthcare.gov\immigrants\immigration-status\).  This option to provide Medicaid coverage to lawfully residing children and/or pregnant women without a 5-year waiting period has been elected in 29 states, plus the District of Columbia and the Commonwealth of the Northern Mariana Islands. Twenty-one of these states also cover lawfully residing children or pregnant women in CHIP. [Find out if your state has this option in place](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&150&&&http://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/lawfully-residing.html).

*Treatment for an Emergency*

Medicaid provides payment for treatment of an emergency medical condition for people who meet all Medicaid eligibility criteria in the state (such as income and state residency), but don’t have an eligible immigration status.

*Medicaid, CHIP, and “public charge” status*

Applying for Medicaid or CHIP, or getting savings for health insurance costs in the Marketplace, doesn’t make someone a “[public charge](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&151&&&http://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge).” This means it won’t affect their chances of becoming a Lawful Permanent Resident or U.S. citizen. There’s one exception:  People receiving long-term care in an institution at government expense may face barriers getting a green card.

**Assister Q&A on Deep Dive: Eligibility for Non-Citizens in Medicaid and CHIP” Webinar**

CMS

Q: How can local agencies access the federal funds that are available for oral interpretation and written translation provided to Medicaid and CHIP applicants and beneficiaries?

A: State Medicaid agencies may receive federal matching funds for oral interpretation and written translation services.  Local agencies can discuss with state Medicaid agencies the provision of accessible information to individuals, and whether the state is claiming federal funds for language services.  Some state agencies partner with community based organizations to assist in the provision of language services to applicants and beneficiaries, either through oral interpretation or written translations.

Q: Are the federal funds for oral interpretation and written translation provided to Medicaid and CHIP applicants and beneficiaries only available to states that expanded Medicaid?

A: No, the federal funds that can be claimed for language services are available to all states, regardless of whether or not the state has expanded Medicaid to cover low income adults.  Enhanced federal match for language services for Medicaid and CHIP were established by the Children’s Health Insurance Reauthorization Act of 2009 (CHIPRA).

Q: Can consumers who are only eligible for Medicaid coverage of treatment of an emergency medical condition also have coverage through the Marketplace with financial assistance?

A: Yes, if the individual meets the Marketplace eligibility criteria (however many individuals who seek coverage of an emergency medical condition through Medicaid may not meet the immigration eligibility requirements for Marketplace coverage).  The Marketplace does not consider Medicaid payment for treatment of an emergency medical condition to be minimum essential coverage (MEC).  Therefore, an individual who meets all the eligibility criteria for Marketplace coverage would not be prohibited from enrolling in a Marketplace plan with advance payments of the premium tax credit (APTC) and/or cost-sharing reductions due to having Medicaid coverage for treatment of an emergency medical condition. For individuals with both types of coverage, the Marketplace coverage would be the primary, and Medicaid the secondary, payer.

Q: Are individuals holding H2A visas eligible to apply for tax credits and subsidies?

A: Yes, an individual with a valid H2A visa is considered lawfully present and meets the immigration eligibility requirement for Marketplace coverage. Such an individual is also eligible to receive APTC and CSRs, if otherwise eligible.

Q: If a consumer’s dependent has a foreign address (for example, a child studying abroad), how should they include the dependent’s address on the application?

A: HealthCare.gov gives applicants the option to use the same address as they list for themselves when listing their dependents, or to input a different address. Because the system does not accept foreign addresses, an applicant claiming a tax dependent who is temporarily living abroad should choose to use the same address for that dependent as they have listed for themselves.

Q: Can information obtained in an application, such as immigration status, be used for immigration enforcement purposes?

A: No. Information provided by applicants or beneficiaries won’t be used for immigration enforcement purposes.  For more detail, see the US Department of Homeland Security statement [here](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&152&&&http://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf).

Q: When does the Medicaid five-year waiting period start for qualified non-citizens?

A: The five-year waiting period begins on the date the individual receives his or her qualified immigration status.   The five year waiting period only applies to certain qualified non-citizens who entered the country after August 22, 1996.   For more information on qualified non-citizens and the five year waiting period, visit [this page](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMzMxLjQzNjcwNzcxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDMzMS40MzY3MDc3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3NDI2OTI1JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&153&&&https://www.healthcare.gov/immigrants/lawfully-present-immigrants) on HealthCare.gov.

Q: A couple who enrolled in QHP coverage on the Marketplace received notices saying they must provide documents proving their immigration status to the Marketplace or they will lose their coverage. Once they submit documents, how can we be sure that their data matching issue has been resolved?

A: The consumers should upload or mail any required documents to the Marketplace as proof of their immigration status. Consumers can check their account online or call the Call Center to check on the status of the data matching issue.

Q: Do parents without an eligible immigration status who apply for coverage on behalf of their citizen or lawfully-present children   have to provide any information regarding their own immigration status?

A: No, non-applicants who are not applying for coverage for themselves will not be asked to provide information about their citizenship or immigration status because it is not relevant to the determination of the applicant. The application may ask for the non-applicant’s social security number, but only to verify other information provided on the application related to the applicant’s eligibility.

Q: Do parents without an eligible immigration status have to provide a social security number (SSN) in order to apply for coverage on behalf of their children?

A: No, providing a social security number is optional for those who do not have one. However, when possible, entering an SSN makes the application process go smoother and faster by allowing the Marketplace to check your information that is necessary to determine eligibility for an applicant.

Q: Are adults with incomes below 100% FPL eligible for APTC through the Marketplace if they have met the Medicaid 5-year bar but do not meet other state Medicaid immigration requirements?

A: Yes, an individual with income below 100% FPL who is lawfully present but is ineligible for Medicaid due to immigration status may be eligible for APTC and CSRs through the Marketplace, if otherwise eligible.  A small number of states have Medicaid immigration requirements in addition to the five-year bar (e.g., requirements for Lawful Permanent Residents (green card holders) to work 40 quarters).

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Have something you want us to possibly add to next week’s newsletter? Email Kim VanPelt at [kim.vanpelt@slhi.org](mailto:kim.vanpelt@slhi.org).