Health Connector Policy:
Eligibility for Federal and State Financial Support for Individual/Family Plan

Policy #: **NG-1B**	Date revised: **4/21/2016**
Category: **Eligibility**	Effective date: **1/1/2016**
Approved by: **Ed DeAngelo**	

Applicable to all Non-Group products (Qualified Health Plan and Qualified Dental Plans)

This policy outlines the forms of financial assistance and the eligibility criteria.

Individuals/families may be eligible for financial assistance if they meet the following criteria:

- Are enrolled in a Health Connector Plan (Qualified Health Plan or a Qualified Health Plan and a Qualified Dental Plan)[1,2]
- Have a projected annual modified adjusted gross household income (MAGI) less than or equal to 400% of the Federal Poverty Level (FPL).

1. **Advance Premium Tax Credit ("APTC" or "Tax Credits").** An APTC is a federal tax credit that is provided to an issuer (insurer) on behalf of an eligible individual or family. The tax credit reduces the cost of Essential Health Benefits covered by a health or dental insurance plan.
    a. To qualify for tax credits, an individual/family must:
        i. Be eligible for and enroll in a Qualified Health Plan (other than a Catastrophic health plan) through the Health Connector;[1]
        ii. Have a projected annual modified adjusted gross household income (MAGI) between 100% and 400% of the Federal Poverty Level (FPL). Lawfully present resident aliens with MAGI under 100% who are ineligible for Medicaid may also be eligible for tax credits (assuming they meet other eligibility criteria);
        iii. Not be eligible for or enrolled in other qualifying minimum essential coverage, such as Medicare, Medicaid, or affordable employer-sponsored insurance that meets minimum value requirements;
        iv. Attest that s/he will file taxes for the year during which a tax credit is received. Married couples must file jointly in order to be eligible to receive a tax credit with the exception of victims of domestic violence or spousal abandonment.

    b. The individual/family's maximum tax credit eligibility is calculated by the Internal Revenue Service by subtracting the tax household's expected contribution from the cost of the Second Lowest Cost Silver Plan premium. The tax household's expected contribution of premiums is based on household MAGI and family size and is determined annually by the Internal Revenue

Service.[3]

c. The individual/family may elect to take the maximum amount or any lesser amount of tax credits for which s/he is eligible.

d. The tax credits may be used to reduce the cost of any QHP and QDP, other than a Catastrophic Plan, offered through the Health Connector.

    i. Tax credits may only be applied to the portion of a Qualified Health Plan that covers Essential Health Benefits or Qualified Dental Plan that covers the pediatric dental Essential Health Benefit, but may be applied to multiple health and dental plans within a tax household;

    ii. An individual/family may only apply tax credits to a Qualified Dental Plan if they have applied the maximum amount of tax credits to their Qualified Health Plan and there are credit funds remaining;

    iii. An individual/family may reduce the amount of his/her tax credit or increase it up to the maximum tax credits for which s/he is eligible at any time during the benefit year.

e. The individual/family will be required to reconcile the total tax credits actually received during the benefit year against the tax credits which the individual/family is eligible to receive based on annual income as reported on their federal tax return.

    i. If the advance payments exceed the amount of the credit an individual/family is eligible for, a portion of the overpayment must be repaid to the Internal Revenue Service (IRS);

    ii. If the advance payments are less than the amount of the credit an individual is eligible for, the individual/family may receive the remaining credit when they file.

f. Tax credits are paid directly to the issuer (insurer) by the federal government.

g. The Health Connector is not liable for payment of the tax credit to or on behalf of any enrolled individual/family. The federal government provides the tax credit directly to the issuer.

2. **Federal cost sharing reductions (CSR) for non-Indians.** Cost sharing subsidies reduce the out-of-pocket expenses (co-pays, co-insurance, and deductibles) for a qualified individual/family for Qualified Health Plans only. To qualify for a cost sharing reduction, an individual/family must:

    a. Be eligible for and enroll in a ConnectorCare plan through the Health Connector; and

    b. Have a household MAGI less than or equal to 250% FPL.

3. **Federal cost sharing reductions for Indians.** Additional cost sharing reductions are available to an individual who is an Indian as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. §450b(d)).

    a. An individual/family enrolled in a Qualified Health Plan through the Health Connector who is an Indian will not be responsible for any cost sharing requirement for an item or service furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian

Organization or through referral under contracted health services.

b. An individual/family eligible for and enrolled in a Qualified Health Plan with a tax credit through the Health Connector who is an Indian with a household MAGI less than 300% FPL will not be responsible for any cost sharing under the plan.

4. **ConnectorCare.** Through the ConnectorCare program, a qualified individual/family may receive premium and cost sharing subsidies for their Qualified Health Plan, in addition to federal tax credits and federal cost sharing reductions.
   a. To qualify for premium and/or cost sharing subsidies under ConnectorCare, an individual/family must:
      i. Be eligible for and enroll in a Qualified Health Plan with a tax credit through the Health Connector;
      ii. Have a household projected annual MAGI income less than or equal to 300% FPL; and
      iii. Enroll in a designated ConnectorCare plan as described below.

   b. The Health Connector calculates the maximum amount a ConnectorCare-eligible individual/family is eligible to receive in addition to any tax credits or cost sharing reductions based on household MAGI and family size.

   c. The premium and cost sharing in a ConnectorCare plan will be available only if the eligible individual/family enrolls in a Qualified Health Plan that is specifically designated by the Health Connector as a ConnectorCare plan.

   d. The premium and cost sharing in a ConnectorCare plan will be paid directly by the Health Connector to Qualified Health Plan issuers.

   e. Individuals/families will be responsible to pay the difference between the cost of the Qualified Health Plan and the amount of any premium subsidy. The Health Connector will collect that contribution from ConnectorCare-eligible individuals/families. The cost of ConnectorCare plans will vary. Individuals/families who choose the least expensive ConnectorCare plan available to them will pay the lowest premium applicable for their income level, while individuals/families who choose more expensive plans will pay higher premiums. Cost sharing will be the same across all ConnectorCare plans.

   f. The state subsidy paid through the ConnectorCare program is not part of a tax credit program. While ConnectorCare members are required to file federal tax returns to reconcile any tax credits they received to help pay for their ConnectorCare plan, they are not required to file state tax returns (unless otherwise required by law).

Provisional eligibility for subsidized coverage

An individual/family may receive Advance Premium Tax Credits and, if eligible, cost sharing reductions through ConnectorCare, while they are in a provisional period for eligibility. Any advance payments of the

premium tax credit received during the 90-day provisional eligibility period are subject to Federal Income Tax reconciliation.

Individuals/families are provisionally eligible for coverage if they attest to meeting the eligibility requirements outlined in the previous sections, but they must provide further documentation of their eligibility because the Health Connector could not verify their information using other electronic data sources. An individual may not be provisionally eligible if electronic data sources indicate they are deceased or they have Minimum Essential Coverage from another public program, including Medicare or MassHealth.

In the case of provisional eligibility, the individual/family will have 90 days to provide documentation, during which time s/he will be eligible based on the attestation(s) provided in the application. If, after the 90 days, the Health Connector remains unable to verify the attestation, the individual/family's eligibility must be re-determined based on the information available in the data sources.[4]

The Health Connector may extend the provisional eligibility period if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period.

[1] *Please reference the policy Eligibility for Individual/Family Plan (NG-1A)*

[2] *Please reference the policy Enrollment in Individual/Family Plan (NG-3)*

[3] *Please reference 26 CFR 1.36B(3)*

[4] *Please reference the policy Redetermination During the Benefit Year (NG-2)*