THE ADVISOR

National Marketing Group Services, Inc.
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Health Insurance Exchanges (Marketplaces)

Establishment of Health Insurance Exchanges and SHOPs

Exchanges (also known as Health Insurance Marketplaces) provide an option for individuals to buy private health insurance. The Exchanges also operate the Small Business Health Options Program (SHOP) as an option for qualified small employers to purchase employee health coverage. The U.S. Department of Health and Human Services (HHS) has issued final rules relating to Exchanges which include standards for:

- The establishment and operation of an Exchange;
- Health insurance plans that participate in an Exchange;
- Determinations of an individual's eligibility to enroll in Exchange health plans and in insurance affordability programs;
- Enrollment in health plans through Exchanges; and
- Employer eligibility for and participation in SHOPs.

Exchanges perform a variety of functions, including certifying health plans as "qualified health plans" to be offered in the Exchange; operating healthcare.gov to facilitate comparisons among qualified health plans; determining eligibility of consumers for enrollment in qualified health plans and for insurance affordability programs (such as premium tax credits, Medicaid and CHIP); and facilitating enrollment of consumers in qualified health plans.

The federal government operates “federally-facilitated Exchanges” in states that did not elect to establish their own state-based Exchange, while some states operate a hybrid State Partnership Exchange in which the state runs certain functions.

Small Business Health Options Program (SHOP)

In all states except Hawaii, Exchanges are required to operate a SHOP as an option for qualified small employers to purchase employee health coverage. The federal government operates the program in states that did not elect to establish an Exchange. Employers located in a state operating its own SHOP Exchange must follow that state's application and enrollment process.
Under the law, SHOPs must allow employers the option of offering employees all qualified health plans (QHPs) at a single level of coverage. Employers are able to choose the level of coverage to offer (bronze, silver, gold, or platinum), define their contribution toward employees' coverage, and then offer the employees choices of multiple insurers and plans. In addition, SHOPs may allow employers to offer one or more QHPs to employees by other methods, such as allowing the employer to choose a single QHP for employees.

Employer Participation in SHOPs

The final rules outline the basic standards employers must meet to voluntarily participate in a SHOP.

Employer Eligibility

The final rules provide that an employer is a qualified employer eligible to purchase coverage through a SHOP if such employer:

- Is a small employer (in most states, this is defined as 50 or fewer full-time equivalent employees for 2014--beginning in 2016, employers with up to 100 employees will be eligible to participate);
- Elects to offer, at a minimum, all full-time employees coverage in a qualified health plan through a SHOP; and
- Either—
    - Has its principal business address in the Exchange service area and offers coverage to all its full-time employees through that SHOP; or
    - Offers coverage to each eligible employee through the SHOP serving that employee's primary worksite.

A qualified employer may continue to participate in a SHOP if it ceases to be a small employer due to an increase in the number of employees, until the employer either fails to meet the other eligibility criteria or elects to no longer participate in the SHOP.

Note: The federal government has made available a SHOP Full-Time Equivalent Employee Calculator for employers to determine whether they might qualify for SHOP. (Some states that run their own SHOP Marketplaces count FTEs for SHOP eligibility differently. Employers located in a state that runs its own SHOP Marketplace should contact the SHOP Marketplace to learn more.)

A separate set of final rules includes standards governing the definitions and counting methods used to determine employer size and full-time status of employees for purposes of Exchanges and SHOP participation.

Standards for Employer Participation in a SHOP

Under the final rules, the following standards apply for small employer participation in a SHOP:

- Each SHOP will set a uniform process and timeline for each employer seeking to become a qualified employer through the SHOP. A qualified employer may make coverage in a qualified health plan available to employees through the SHOP according to the process established.
- A qualified employer participating in a SHOP must provide certain information to its employees about the methods for selecting and enrolling in a qualified health plan, including:
    - The timeframes for enrollment;
    - Instructions for how to access the SHOP web site and other tools to compare qualified health plans; and
    - The SHOP toll-free hotline.
- Qualified employers must provide employees hired outside of the initial or annual open enrollment period with a specified period to seek coverage in a qualified health plan beginning on the first day of employment, as well as certain information about the enrollment process.
- A qualified employer participating in a SHOP also must provide the SHOP with information about individuals or employees whose eligibility to purchase coverage through the employer has changed, including newly eligible individuals as well as those no longer eligible for coverage (for example, due to a COBRA qualifying event).
- An employer may begin participating in a SHOP at any time. The employer's plan year consists of the 12-month period beginning with the qualified employer's effective date of coverage. The SHOP must provide qualified employers with a period of no less than 30 days prior to the completion of the employer's plan year and before the annual employee open enrollment period, in which the qualified employer may change its participation in the SHOP for the next plan year.
    - Once an employer begins participating in a SHOP, it must adhere to the annual employer election period during which it may change employee offerings for the next plan year.

Health Insurance Premium Tax Credit

The premium tax credit (PTC) helps eligible individuals with low or moderate income pay for health insurance bought through the Health Insurance Exchange (or Marketplace). If an eligible individual chooses advance payment of the credit, the Exchange will estimate a credit that is paid directly to the individual’s insurance company to lower the cost of the monthly premium. Alternatively, individuals eligible for the credit can elect to receive the credit themselves when they file their tax

returns for the year. If the credit is more than what the person owes in taxes, or if the person owes no taxes at all, the person will receive a refund.

Eligibility Requirements

Who is eligible for the premium tax credit?
In general, an individual is eligible for the premium tax credit if he or she meets all of the following requirements:

- Purchases coverage through the Exchange.
- Has household income that falls within a certain range.
- Is not able to get affordable coverage through an eligible employer plan that provides minimum value.
- Is not eligible for coverage through a government program, like Medicaid, Medicare, CHIP or TRICARE.
- Files a joint return, if married (victims of domestic abuse and spousal abandonment may claim the premium tax credit using "Married Filing Separately" if certain requirements are satisfied).
- Cannot be claimed as a dependent by another person.

For more information about these eligibility requirements, please visit the IRS webpage on Eligibility for the Premium Tax Credit. You can also use the IRS interactive Premium Tax Credit Tool to see if you qualify. An Eligibility Chart is also available.

Additional Resources

- IRS Questions and Answers
- IRS Form 8962, *Premium Tax Credit (PTC)*
- Publication 974: Premium Tax Credit (PTC)

Individual Mandates

Federal Mandate

On Jan. 1, 2019, the federal individual mandate under the Affordable Care Act (ACA) was effectively repealed. As a result, beginning with tax year 2019, a federal tax penalty no longer applies to individuals without health insurance coverage. For help with individual mandate compliance in prior tax years, click here.

Should you have additional questions or need assistance, please contact **NMGS** at 305 592-9926 or by email customerservice@mynmgs.com

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