COVERED

CALIFORNIA

2. Covered California Overview

2.1 Affordable Care Act

2.1.1 Patient Protection and Affordable Care Act Overview

The Patient Protection and Affordable Care Act (ACA), also known as, Health Care Reform (HCR) was signed into law on March 23, 2010. ACA increased access to health insurance benefits by providing affordable coverage and financial assistance. The State of California enacted legislation to establish Covered California (Covered CA), the California Health Benefit Exchange. Covered CA is the place where Californians can get brand-name health insurance under ACA and utilize tax credits to reduce their monthly health premiums. Individuals can apply online, over the phone, by mail or in person and may be eligible for federal premium assistance on private insurance, Medi-Cal (MC) or consumer protection programs (such as Soft Pause).

Many changes occurred following the implementation of ACA: insurance companies cannot deny applicants with preexisting conditions, there are no annual or lifetime limits, essential services are included in health plans, and insurance companies must follow rules for increasing rates for clients. The initial open enrollment for Covered CA began in October 2013, allowing applicants to receive their new health plan benefits as early as January 1, 2014. Covered CA began offering a range of health care coverage, making it easier and affordable for individuals and small businesses to purchase health insurance.

2.1.2 Health Care changes since 2014

The ACA changed many aspects of healthcare and insurance in the United States of America. These changes are as follows:

Increased Access to Health Insurance

The ACA established state exchanges, where individuals and small businesses shop for health insurance online, in person or by phone.

Affordable Coverage and Financial Support

Individuals and families with low to moderate income may qualify for federal financial assistance.

Guaranteed Availability of Coverage

All health insurance plans (except most sold before March 10, 2010) cover individuals regardless of pre-existing health conditions. Insurance companies cannot drop clients from health insurance for getting sick or making a mistake during the application process.

Young Adult Coverage

Dependents up to the age of 26 may remain covered under their parent's employer-sponsored plan.

Preventive Care

All health plans must cover preventive care and medical screenings like mammograms and colonoscopies, recommended immunizations, and additional preventive care and screenings for women. Health insurance companies cannot charge copayments, coinsurance, or deductibles for such services when the insured is using a contracted doctor or hospital within the health plan's network.

Essential Health Benefits

Newly sold health plans cover services that fall into 10 categories of Essential Health Benefits or Minimum Essential Coverage.

Health Benefit Standard

Four benefit categories of plans (Bronze, Silver, Gold, and Platinum) are available to choose from, so applicants can compare plans and see expected costs [Refer to "Metal Tiers," page 2-18]. Additionally, a separate Basic Coverage Plan is available. A Basic Coverage Plan (Catastrophic plan) helps protect a person from financial disaster in the event of a serious and expensive medical emergency.

- This plan does not cover (non-preventive) day-to-day medical expenses such as doctor visits, prescription medicines, or emergency room visits.

- It covers excessive medical bills that occur above the limit that one would be able to manage financially.

- A certification is required to indicate that an individual is without affordable coverage or experiencing hardship.

No Lifetime or Annual Limits

Health plans cannot put a lifetime dollar limit on most benefits.

Consumer Assistance Program

New federal grants help states improve their consumer assistance programs to help applicants with filing complaints and appeals, enrolling in health coverage, and getting educated about their rights.

Penalties for No Coverage

Beginning 2014, most people over age 18 are required to maintain public or private health insurance or pay a financial penalty on their taxes. **Tax filers receive penalties for tax dependents without coverage.**

Business Healthcare Requirements

Employers with 50 or more full-time equivalent employees that do not offer affordable insurance or coverage that meet minimum standards started receiving penalties in 2014. Businesses with fewer than 50 full-time equivalent employees that do not provide health coverage do not face a penalty but are encouraged to consider affordable employee coverage options.

Rate Increase Rules

Health insurance companies must justify premium increases. Insurance companies are required to spend 80 percent of the premium dollars on quality healthcare, not administrative costs like salaries and marketing.

Small Business Premium Assistance

Small businesses purchasing health insurance may qualify for premium assistance to help offset the cost of enrolling employees in health insurance.

2.1.3 Health Insurance Exchange

Health Insurance Exchanges create a competitive market for health insurance, provide a choice of health plans, establish common rules regarding the offering and pricing of health insurance, and provide information to help applicants better understand their options. Covered CA is the Health Benefit Exchange in California; other states may have created their own exchanges or use the Federal Health Benefit Exchange. Several key features of Health Benefit Exchanges include:

- Certified health plans
- Enrollment coordination
- Telephone assistance hotlines
- Internet websites
- Uniform enrollment forms
- Online cost calculators
- Premium assistance for eligible individuals and families
- Cost sharing reduction for eligible individuals and families
- Tax credits for eligible small businesses

2.2 Minimum Coverage Provision

The ACA will require most U.S. Citizens and Legal Permanent Residents (LPRs) to obtain and maintain Minimum Essential Coverage (MEC) for themselves and their dependents, or pay a penalty.

Examples of coverage include:

- Health coverage purchased through Covered CA
- Health coverage purchased directly from a provider if it meets MEC (i.e. Blue Shield)
- Foreign health coverage

- Certain employer-sponsored insurance (if the plan meets MEC and financial requirements); this includes coverage offered to former employees, such as COBRA, and retiree medical coverage
- Public insurance such as Medi-Cal
- Refugee Medical Assistance (RMA)
- AmeriCorps coverage offered to AmeriCorps volunteers, which is a domestic counterpart to the Peace Corps
- Certain types of Veterans coverage (Veterans health care program, Civilian Health and Medical Program (CHAMPVA), or Spina Bifida Health Care Program)
- Self-funded student health insurance plans
- Medicare plans for individuals over 65 or disabled

2.2.1 Minimum Essential Coverage (MEC)

Providers offering health insurance through Covered CA are required to provide certain services to meet the minimum essential coverage requirement. Similarly, a client is required to maintain health insurance with the following services to avoid a tax penalty.

(1) Ambulatory services,

(2) Emergency services,

(3) Hospitalizations,

(4) Maternity and newborn care,

(5) Mental Health and substance use services,

(6) Rehabilitative and habilitative services,

(7) Laboratory services,

(8) Preventive, wellness, and chronic disease management,

(9) Pediatric Services, and

(10) Prescription drugs

ACA requires individuals to maintain health insurance. If an individual or family does not maintain health coverage, the Internal Revenue Service (IRS) will impose a tax penalty.

Table 2-1: Healthcare and MEC Requirement

Healthcare is NOT Required if client is… ***(No Penalty)***	**MEC is met if client has…** ***(No Penalty)***
• Part of a religion opposed to the acceptance of benefits from a health insurance policy • An undocumented immigrant • Incarcerated • An American Indian/Alaskan Native • Below the threshold for filing a tax return ("Tax Filing Threshold," page 2-11) • Required to pay more than 9.5% of total income for available health insurance, after taking into account any employer contributions or tax credits	• Medicare • MC or Children's Health Insurance Program (CHIP) • TRICARE (for service members, retirees, and their families) • Veterans health care program • An employer-sponsored program that meets the 60% minimum value provision • Private insurance that meets MEC • A grandfathered health plan in existence before 1/1/2014

2.3 Health Insurance Fundamentals

Health insurance provides individuals with financial assistance covering costs related to injuries, illnesses, or hospital stays. ACA places an emphasis on preventive care. Routine doctor visits cost less; managing health or treating health concerns is more affordable. All plans include preventive care and wellness services at no out-of-pocket cost to the client. Services cost less with insurance because health plans negotiate lower rates.

Applicants include:

- Those who have never purchased health insurance before.
- Underinsured individuals looking for different coverage.
- Individuals who need help understanding how health insurance works.

- Individuals who need help understanding the value of health insurance.

Understanding insurance:

- Insurance pays for some or all of a person's healthcare costs.
- The covered person may pay a monthly premium.
- The covered person may share in the healthcare costs (copayment, coinsurance, deductible).

2.4 Types of Insurance

People buy insurance to stay healthy or for financial protection following an accident or illness. The insured person may pay a monthly premium to the health insurance company. The health insurance company pays some or all of the person's healthcare costs.

There are two types of insurance in the U.S.

Private Health Insurance

Provided by health insurance companies to individuals, families, and businesses. Some people buy private insurance directly as an individual or family; others get insurance through their employers.

Public Health Insurance

Provided by the government. An example is Medicare, which provides coverage to people age 65 years and older, as well as people with disabilities. MC in California is another type of public health insurance that assists low-income individuals. Both Medicare and MC contract with private health insurance companies to provide these government programs.

2.4.1 Managed Care

In the United States, managed care plans make up the majority of both private and public health insurances. These plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Exclusive Provider

Organizations (EPOs). Networks of doctors and hospitals contract with health insurance companies to provide quality and predictable cost. Health insurance company staff ensures that health services are medically necessary; some services and procedures require pre-approval from the health insurance company. Most health plans provide education to manage health and chronic illnesses.

2.4.2 Non-Managed Care

Non-managed care plans:

- Allow clients to direct their own care.
- Have no contracts with doctors or hospitals.
- Usually, require clients to pay the full cost of services up front before filing claims for reimbursement.

2.4.3 Health Maintenance Organization

An HMO is a health plan that connects a member with a primary care physician (PCP) or a team of physicians. The PCP/care team coordinates all of the member's care. Doctors, specialists, and hospitals in the HMO network provide all services. HMOs generally do not cover out-of-network costs except in emergencies. All plans require members to live in specific geographic service areas. All plans provide preventive care.

2.4.4 Preferred Provider Organization

A PPO is a health plan that creates a network of preferred or participating doctors and hospitals by contracting with doctors and hospitals. Members pay less when they use a network provider, although members may choose providers where they access services.

2.4.5 Exclusive Provider Organization

An EPO works like an HMO, members have access to the health plan's EPO network, which usually offers more limited doctor choices than a PPO. The health plan does not cover any services that members get from out-of-network doctors and hospitals, except in emergencies.

2.5 Insurance Options through Covered CA

Covered CA is an insurance marketplace for Californians providing affordable public and private healthcare options for individuals or small businesses. Covered CA has standardized the benefits so that a client can make accurate comparisons among the health plans offered in their geographic service area.

Covered CA requires additional standards for health plans to receive certification as a Covered CA Health Plan. Covered CA Health Plans must:

- Be licensed and in good standing with the State.
- Obtain a Certification of Authority as an insurer.
- Participate in Covered CA's competitive active purchaser solicitation; which includes evaluation based on quality, price, and accessibility.

Covered CA considers member satisfaction scores, accreditation, and third-party rankings when certifying health plans. Covered CA health plans are subject to routine quality checks to evaluate performance, healthcare quality, and outcomes. These measures are consistent with the Code of Federal Regulations CFR§155.200, designed to continually improve quality. Covered CA monitors health plan performance and annually recertifies plans that continue to meet the required standards. Industry organizations also monitor and evaluate health plan quality.

2.5.1 Provider Network Directories

The client can search for doctors and hospitals using provider network directories by type or specialty care services, name, gender, language(s) spoken, etc.

HMO, PPO, and EPO Networks

Most health plans are building custom networks for Covered CA. PPO and EPO plan networks are often larger, and feature thousands of doctors and hospitals.

Customized Networks

Some health plans also offer narrow, tailored, or selected networks. Each of these networks is a subset of one of the carrier's main networks. They are often specific to a certain geographic area and include doctors, hospitals, and medical groups that meet criteria for cost efficiency and access.

CalHEERS Network Directory

The CalHEERS online directory is a centralized database of all the doctors that participate in any one or more of the networks associated with Covered CA Health Plans.

2.6 Tax Filing Threshold

The tax filing threshold identifies whether an individual is required to file taxes, depending on age and tax filing status.The 2016 tax filing threshold amounts can also be found on the IRS website.

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Table 2-2: 2016 Federal Tax Filing Threshold

Filing Status	Age	Individual must file a tax return if gross income exceeds...*
Single	Under 65	$10,350
	65 or older	$11,900
Head of Household	Under 65	$13,350
	65 or older	$14,900
Married Filing Jointly	Under 65 (both spouses)	$20,700
	65 or older (one spouse)	$21,950
	65 or older (both spouses)	$23,200
Married Filing Separately	Any age	$4,050
Qualifying Widow(er) with dependent children	Under 65	$16,650
	65 or older	$17,900

Table 2-2: 2016 Federal Tax Filing Threshold

Filing Status	Age	Individual must file a tax return if gross income exceeds...*
Dependents	Under 65	$6,300
	65 or older	$7,850

*A tax penalty will be assessed if client does not maintain MEC.

2.7 Acceptable Applications

Applicants can apply in person, over the phone, online, by mail, or fax.

The Single Streamlined Application (SSApp) [CCFRM 604] applies to all health coverage programs, including MC, Advanced Premium Tax Credit (APTC)/Cost Sharing Reduction (CSR), and unsubsidized coverage. The MC 210, MC 321 HFP, and SAWS 2 are no longer being printed but may still be accepted from applicants and used to input client information; additional forms such as the Request for Tax Household Information (RFTHI) may be required to obtain sufficient information to evaluate eligibility. The SAWS 2 PLUS is also an acceptable application for health coverage programs.

Note:
If an applicant is applying for CalFresh (CF) using the CF 285 and he/she requests MC, then the tax filing information is also required.

2.8 Quick Sort Transfer

Applicants who call Covered CA to apply for health coverage will be asked a few questions (known as the Quick Sort Questions), such as family size and income. Based on the answers to the Quick Sort Questions, if the caller seems eligible for MAGI MC or Non-MAGI MC, the Covered CA Service Center Representative (SCR) transfers the call to the appropriate county. If the caller's home county is unavailable then either the Covered CA SCR transfers the call to another county or to voicemail (i.e. on county holidays when Covered CA is open).

If the client appears to be eligible for APTC or unsubsidized coverage, the Covered CA SCR will keep the call and process the application and enrollment.

2.8.1 Call Process

A call comes into Covered CA and the SCR asks the Quick Sort Questions to determine potential MC eligibility.

Sample of Quick Sort Questions that are asked by the Covered CA SCR:

- Are you calling Covered CA to understand your health care benefit options?
- How many people are in your family?
- How many children are under the age of 19?
- Are any of your family members pregnant?
- Are any of your family members elderly?
- Are any of your family members disabled?
- What is your annual income?

If the answers to any of the questions make the caller appear eligible for Medi-Cal, then the caller is asked his/her county of residence and the call is transferred to that county.

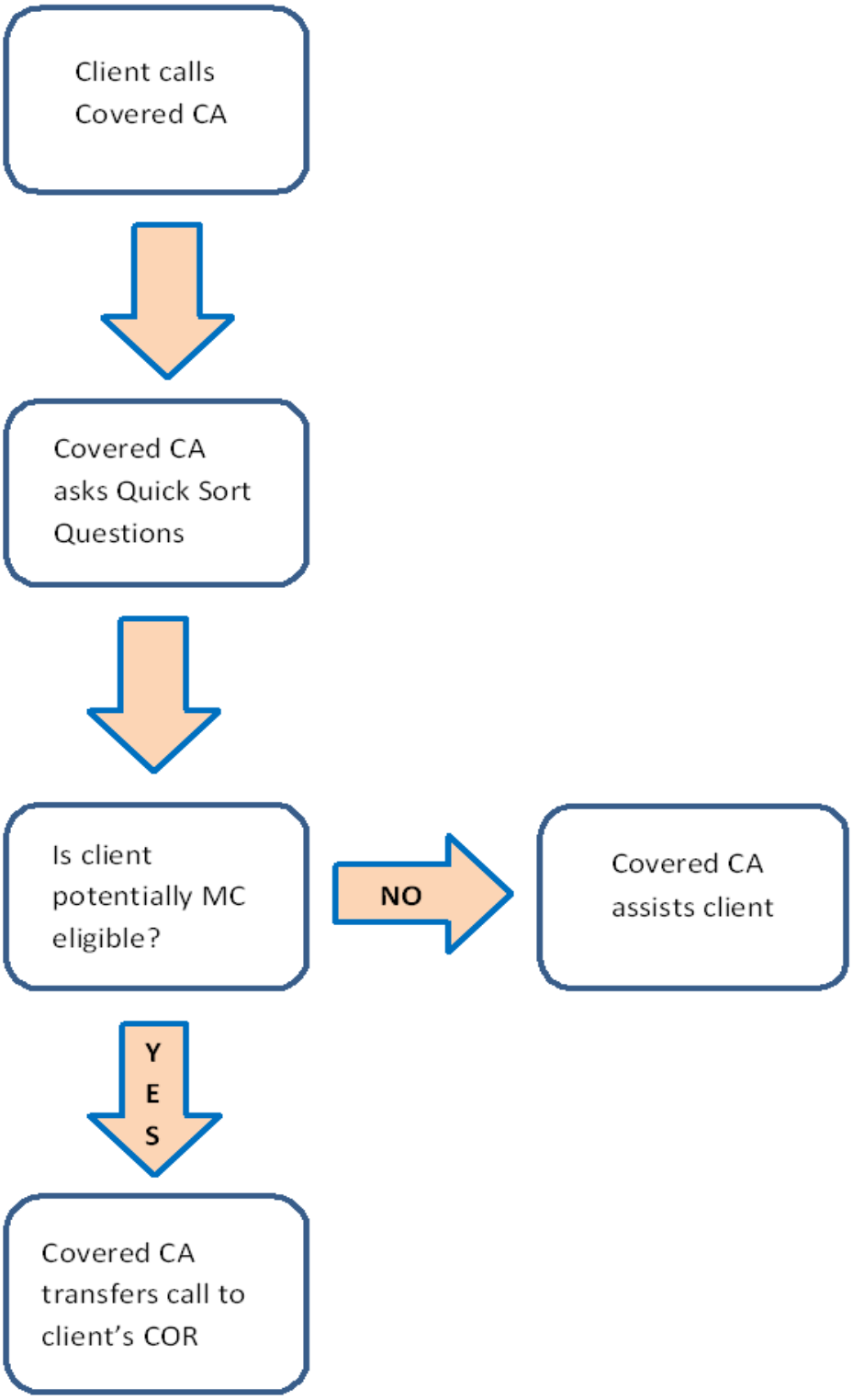
Caller's answers lead Covered CA to transfer the call to:

- Covered CA to County of Residence (COR)
- Covered CA to California Service Center (CSC) Network County

Covered CA stays on the line until the call is transferred (Warm Transfer).

Rollover Calls - If the COR is unable to accept a quick sort transfer call within the 30 second service level, that call will be routed to another county in the consortia.

2.8.2 Quick Sort Transfer Flow



Quick Sort Transfer Home County Scenario

Bill (age 32) calls Covered CA on January 6, 2016 wanting to apply for health benefits for himself. Bill is disabled and earns $1,250/month with no other sources of income. He expects to file a tax return and is not claimed as a dependent by anyone.

Covered CA asks Quick Sort Questions and determines that Bill may be eligible for MC benefits. Covered CA initiates the quick sort transfer to Bill's home county.

2.9 Coverage Enrollment Period

Whereas individuals can apply for MC at any time, they can only enroll or change APTC, CSR, Qualified Health Plan (QHP) during open enrollment, special enrollment, or renewal. If clients, who are eligible for APTC/CSR or QHP, do not choose a health plan during open enrollment, then they will have to wait until the next open enrollment to sign-up, unless special enrollment is applicable.

If a client selects a plan between the first and 15th of the month, the coverage will start the first of the following month.

Example:
A client selects a plan on 3/10/2016; his/her coverage will start 4/01/2016.

If a client selects a plan from the 16th through the end of the month, the coverage will start the first of the second following month.

Example:
A client selects a plan on 3/22/2016; his/her coverage will start 5/01/2016.

Note:
There are no enrollment restrictions for MC.

2.9.1 Open Enrollment

Open Enrollment occurs once a year. It occurs sometime between October and February, usually November 1 through January 31. However, there may be circumstances for an individual or tax filing household that will create a Special Enrollment Period.

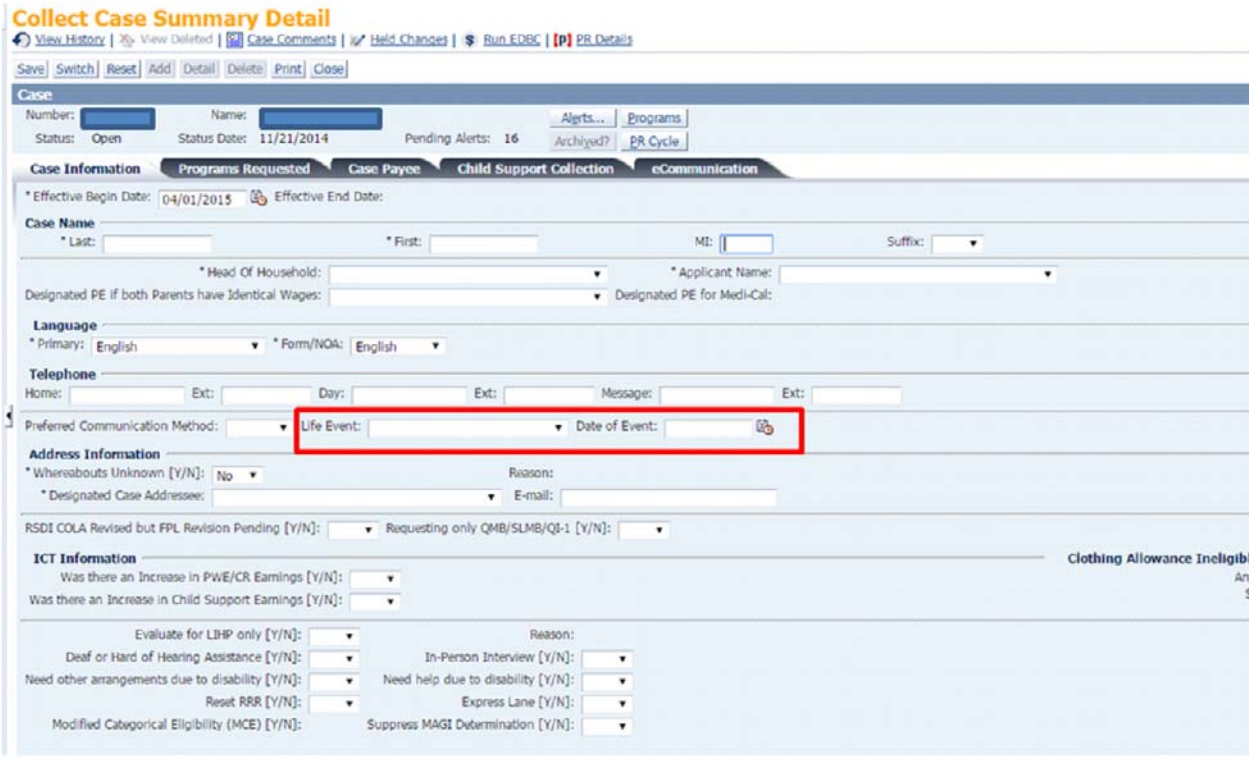
2.9.2 Special Enrollment

Special Enrollment is a period after a qualifying life event, when a client can enroll in a health plan outside of the open enrollment period. The client has 60 days from the date of a qualifying life event to enroll in a health plan or change the existing plan through Covered CA.

Note:
If a client does not enroll within 60 days, he/she must wait until the next open enrollment to sign-up for APTC, CSR, or QHP.

Qualifying life events include:

- Loss of MEC
- Birth of a child
- Change in marital status
- Moving to a new Covered CA region [Refer to "Plan Selection," page 2-36]
- Turning 26 years of age



Note:
Special enrollment is not available for clients who fail to pay insurance premiums or clients who request discontinuance or cancellation of their health insurance plan; clients would need to wait until the next Open Enrollment period following non-payment related discontinuance, voluntary discontinuance, or cancellation.

2.9.3 APTC/CSR/QHP Renewal

All Covered CA renewals (APTC/CSR/QHP annual redetermination process), occur between mid-October through mid-December, giving clients the opportunity to renew their health plan selections. Renewals apply to all subsidized and unsubsidized households who have enrolled in a plan and have made their first premium payment.

Covered CA automatically renews clients, with the exception of clients who choose not to allow automatic renewal and those clients who had significant change in circumstance from one year to the next. If auto-renewal is not available, a manual renewal or manual verification may be required. Clients have a right to appeal renewal decisions. They should contact Covered CA for APTC/CSR or QHP appeal information.

Note:
MC Redeterminations occur throughout the year and may not align with the APTC/CSR/QHP renewal period.

During the Covered CA renewal process, Covered CA clients may become eligible for MC. Refer to the Transitions (MAGI MC/Non-MAGI/APTC) chapter.

2.10 Coverage Available

Covered CA health plans are insurance plans that, starting in 2014, match all the criteria specified in ACA. Covered CA health Plans must:

- Be certified by the exchange
- Provide essential health benefits
- Follow established limits on cost sharing

- Meet other requirements as set by Covered CA
- Hold certification
- Provide insurance to individuals and families with limited income who meet eligibility requirements
- Provide dental and vision coverage for children
- Provide dental coverage for adults

2.11 Metal Tiers

Covered CA health plans are divided into four categories known as Metal Tiers. The higher the metal value, the higher the percentage of health care expenses paid by the health plan. The client can choose from many plans within the four Metal Tiers: **Bronze, Silver, Gold** and **Platinum**. Individual expenses occur at the time of health care services, for example, visiting the doctor or the emergency room. The health plans that cover the larger percentages generally have a higher monthly premium.

Bronze Plan

The insurance plan pays 60% of the health care costs; clients are responsible for the remaining 40% (a combination of deductibles, copayments, and coinsurance).

Silver Plan

The insurance plan pays 70% of the health care costs; clients are responsible for the remaining 30% (a combination of deductibles, copayments, and coinsurance).

Gold Plan

The insurance plan pays 80% of the health care costs; clients are responsible for the remaining 20% (a combination of deductibles, copayments, and coinsurance).

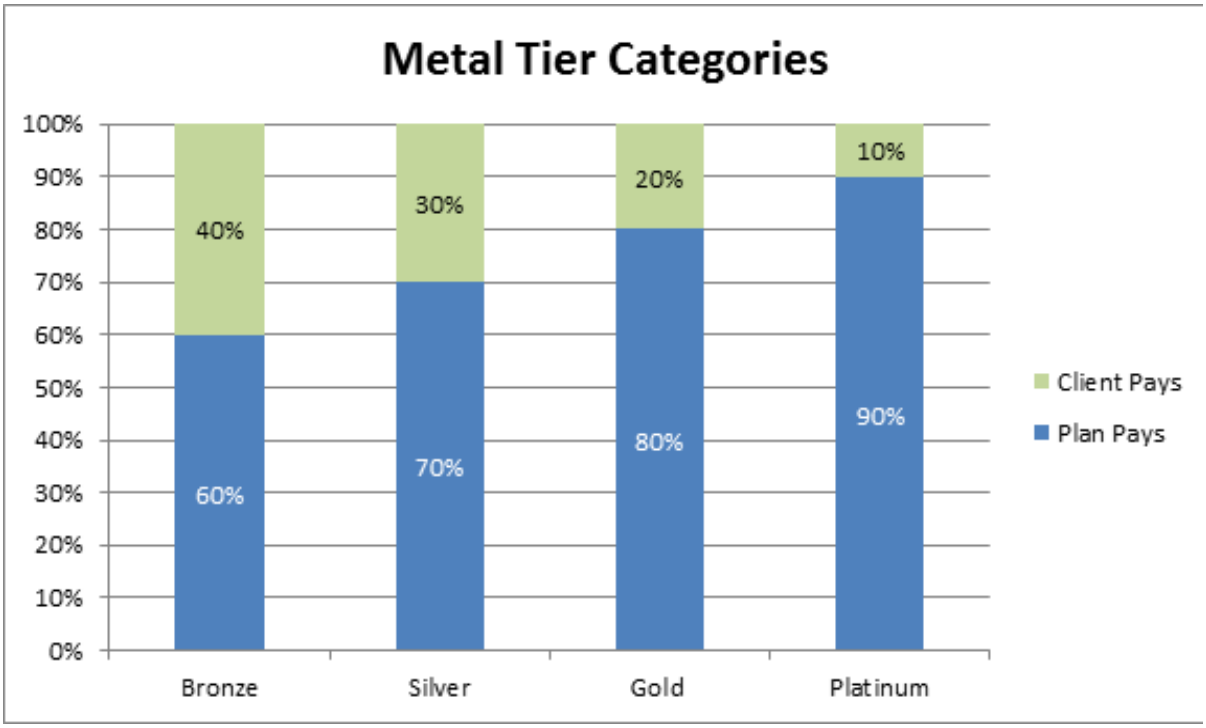
Platinum Plan

The insurance plan pays 90% of the health care costs; clients are responsible for the remaining 10% (a combination of deductibles, copayments, and coinsurance).

Catastrophic Coverage

The basic coverage plan designed for individuals under age 30 who do not have access to affordable coverage.

Note:
Clients covered under the Catastrophic Coverage plan are not eligible for premium assistance, but this plan does meet MEC.



Note:
The Metal Tier Categories chart depicts: **Bronze, Silver, Gold,** and **Platinum**, with the corresponding percentages paid by the plan and by the client.

Before choosing a health plan applicants need to determine what type of coverage they need and want. The Metal Tier system offers a range based on overall health and financial status.

The **Platinum** and **Gold** Tiers are more beneficial to applicants that are going to use the doctor a lot. There is a higher premium, but doctor visits and use of medical services cost less in copayments and coinsurance.

The **Silver** and **Bronze** Tiers have a lower monthly premium, but cost more for medical services and doctor visits. Applicants with good health may not need as much care and may find these plans more cost efficient. Cost Sharing Reduction (Enhanced Silver Plan) also offer lower out-of-pocket payments.

The **Catastrophic Coverage** plan is available to people younger than 30 or to those who have received an exemption from the Health and Human Services due to unaffordability of coverage or hardship. The plan has a low monthly premium but limited services. *Applicants that select this plan are not entitled to APTC*.

Table 2-3: Sample of Deductible, Copayments, and Out of Pocket Maximum by Metal Tier

Key Benefits	Bronze covers 60%	Silver covers 70%	Gold covers 80%	Platinum covers 90%
Deductible	$6,000	$2,250**	No Deductible	No Deductible
Annual Preventive Care Visit Copayment	No cost	No cost	No cost	No cost
Primary Care Visit Copayment	$70*	$45	$35	$20
Urgent Care Visit Copayment	$120*	$90	$60	$40
Emergency Room Copayment	Full cost up to deductible	$250	$250	$150
Generic Medication Copayment	Full cost up to $500 deductible	$15	$15	$5
Annual Out-of-Pocket Maximum for One (1)	$6,500	$6,250	$6,200	$4,000
Annual Out-of-Pocket Maximum for Family**	$13,000	$12,500	$12,400	$8,000

Chart does not include all medical copayments and coinsurance rates.

**For Bronze plans, the deductible is waived for the first three primary care or urgent care visits. Additional visits are charged at full cost until deductible is met.*

***Silver is the only level where the deductible and other costs may be lower based on the household income.*

2.12 APTC/CSR/QHP Eligibility

Beginning January 1, 2014, individuals who meet the following requirements may qualify for APTC, CSR, and QHP:

- No other health coverage - The client cannot have any other health coverage available.
    - Applicants who are eligible for public assistance [i.e. zero Share of Cost (SOC) MC] are ineligible for APTC.

Note:
Applicants cannot refuse zero SOC MC, if they are eligible, in order to enroll into APTC. If applicants refuse MC but still want health coverage, they will have to pay the full-unsubsidized cost for a QHP.

    - Similarly, if a client has employer-offered coverage available where the insurance premium is less than 9.5% of the total tax household annual income and provides up to 60% minimum value, the client is ineligible for APTC.

- Residency - The client must be a California resident (or intend to reside in California)
- Citizenship/Immigration - The client must be a United States citizen/national or lawfully present in the U.S.
- Household composition - Tax filers and the dependents he/she claims are eligible for APTC.
- Income - Based on percentage of Federal Poverty Level (FPL) countable and excluded income is the same for APTC/CSR as for MAGI MC.
- Not incarcerated
- Filing of taxes - Clients must file taxes with the IRS using a tax filing status of *Single*, *Head of Household*, or *Married Filing Jointly*. Applicants filing *Married Filing Separately* or who do not file taxes are ineligible for APTC (with few exceptions) "Married Filing Separately," page 2-24.

2.13 Tax Filing Household

For the purposes of APTC, CSR and QHP, each filing status listed below determines if the household is eligible for a tax credit and who is included in the household premium calculation.

Non-filers may select a QHP at full cost; however, because they do not file taxes they are not eligible for APTC or CSR. For mixed household information with APTC and MC clients, Refer to MAGI MC Tax Household chapter.

DO NOT CHANGE THE TAX FILING INFORMATION WITHOUT THE CLIENTS PERMISSION.

DO NOT GIVE THE CLIENT ADVICE ON HOW TO FILE THEIR TAXES.

Entries in CalWIN and Covered CA directly affect the client's tax information; entering information incorrectly may lead to discrepancies when they file taxes causing penalties, underpayments and/or overpayments. The tax filing household should be entered exactly as the client reports or as stated on their application.

2.13.1 Single

For the purposes of APTC, CSR and QHP, if a person files taxes as *Single* they are counted in a tax household of one.

Example:

Xavier lives in the same home with his 21 year old child, Natalia. Xavier files *Single*. Natalia files *Single*. Xavier and Natalia will require separate CalWIN cases because they are each primary tax filers in their own cases.

2.13.2 Head of Household

For the purposes of APTC, CSR and QHP, tax filers that claim dependents (qualifying relatives or qualifying children), may claim *Head of Household* on their taxes. In this case the tax filing household includes the tax filer and all other persons whom the tax filer expects to claim as tax dependents.

Example:

Sydney is a single mother with four children, she claims two on her taxes and the non-custodial parent outside of the home claims the other two as dependents. For APTC, Sydney's household size is 3.

Married Exception

Some people who are married but do not file taxes with their spouse are eligible for APTC if they qualify and file as *Head of Household*. A married person is considered "unmarried" and is eligible to file as *Head of Household* if he/she can answer YES to each of the following questions:

- Will you file taxes separately from your spouse?
- Will you live apart from your spouse from July 1 to Dec. 31?
- Will you pay more than half of the cost of keeping up your home?
- Will your child, stepchild, or foster child (of any age) live with you for more than half the year?
- Will either you or the child's other parent claim the child as a dependent?

Note:

If the answer is NO to any of the above questions, then the applicant cannot file as *Head of Household* under this exception.

Example:

Marcus is separated from his wife **but not divorced** and will not file taxes together next year. His adult son, Jeremy, is unemployed, living with his dad, and has no other income.

Question: Does Marcus qualify to file as *Head of Household*?

Answer: Yes. Marcus qualifies to file as *Head of Household* because he is considered unmarried by the IRS.

2.13.3 Married Filing Jointly

For the purposes of APTC, CSR and QHP, the household for a married couple filing *Married Filing Jointly* includes the two spouses and all dependents.

2.13.4 Married Filing Separately

Applicants filing *Married Filing Separately* or who do not file taxes are ineligible for APTC (with few exceptions). There are three (3) exceptions when married individuals filing separately may be eligible for a tax credit:

- Victims of domestic violence
- Abandoned spouses
  - Living apart from spouse
  - Unable to locate spouse after diligent search
- Head of Household

2.13.5 Covered CA Tax Filing Household Examples

Married Couple Filing Jointly with Common Children

Antonia and Chang are married and living together with their two children, Serena (15 years old) and Bao (9 years old). Antonia and Chang file taxes jointly and claim both children as tax dependents. The household income is over 266% FPL.

Household Composition

Chang is a tax filer.
Household size = 4 (self, spouse, and 2 dependents)

Antonia is a tax filer.
Household size = 4 (self, spouse, and 2 dependents)

Serena and Bao are tax dependents and do not meet any of the exceptions.
Household size = 4 (same as the tax filer)

Table 2-4: Married Couple Filing Jointly with Common Children

Who	Covered CA HH Size	Who is in the Tax HH	Tax Status or Dependent (i.e. Single, Head of HH, or dependent of mom, etc.)	Primary Tax Filer (Y/N)
Chang	4	Self (Chang), Antonia, Serena, Bao	Married Filing Jointly	Y
Antonia	4	Self (Antonia), Chang, Serena, Bao	Married Filing Jointly	N

Table 2-4: Married Couple Filing Jointly with Common Children

Who	Covered CA HH Size	Who is in the Tax HH	Tax Status or Dependent (i.e. Single, Head of HH, or dependent of mom, etc.)	Primary Tax Filer (Y/N)
Serena	4	Self (Serena), Antonia, Chang, Bao	Dependent of Chang or Antonia	N
Bao	4	Self (Bao), Antonia, Chang, Serena	Dependent of Chang or Antonia	N

Unmarried Parents with Common Child

Unmarried parents, Aksel and Freja, live together with their 1-year-old son, Steffen. Freja has income over 138% FPL and files as *Single*. Aksel files as *Head of Household*, claims Steffen as a tax dependent, and has income over 266% FPL.

Household Composition

Aksel is a tax filer.
Household size = 2 (self and 1 dependent)

Freja is a tax filer.
Household size = 1 (self)

Steffen is a tax dependent of Aksel.
Household size = 2 (self and dad)

Table 2-5: Unmarried Parents with Common Child

Who	Covered CA HH Size	Who is in the Tax HH	Tax Status or Dependent (i.e. Single, Head of HH, or dependent of mom, etc.)	Primary Tax Filer (Y/N)
Aksel	2	Self (Aksel) & Steffen	Head of Household	Y
Freja	1	Self (Freja)	Single	Y
Steffen	2	Self (Steffen) & Aksel	Dependent of Aksel	N

Non-custodial Parent claims Child as a Tax Dependent

Ailani is a single mom living with her 6-year-old son, Sanyi. Sanyi's father, Michael, who is not in the home, claims Sanyi as a tax dependent. Michael claims no one else. Ailani files taxes as *Single* and has income over 138% FPL.

Household Composition

Ailani is a tax filer.
Household size = 1 (self)

Sanyi is a tax dependent of non-custodial parent and he is not eligible for Covered CA programs through the mom.

Table 2-6: Non-custodial Parent claims Child as a Tax Dependent

Who	Covered CA HH Size	Who is in the Tax HH	Tax Status or Dependent (i.e. Single, Head of HH, or dependent of mom, etc.)	Primary Tax Filer (Y/N)
Ailani	1	Self (Ailani)	Single	Y
Sanyi	N/A	N/A	Dependent of Parent not in Home	N

2.14 Income

The table below provides information on how income should be treated when reported by an applicant/client on his/her application or redetermination form.

Table 2-7: Counted and Not Counted Income Type

Type of Income	Counted/Not Counted	IRS 1040 Form
Alimony received	Counted	Line 11
Business (or loss), Schedule C or C-EZ	Counted	Line 12
Capital gain (or loss) [Sale of non-business assets], Schedule E	Counted	Line 13
Child support payments received	Not Counted	Line 21
Dividends, 1099-DIV	Counted	Line 9

Table 2-7: Counted and Not Counted Income Type

Type of Income	Counted/Not Counted	IRS 1040 Form
Education scholarships, awards, fellowship grants **NOT** used for living expense, Pub. 970	Counted	Line 21
Education scholarships, awards, fellowship grants used for living expense, Pub. 970	Counted	Line 21
Employee Compensations (Wages, salaries, tips, bonuses, awards, and fringe benefits)	Counted	Line 7
Farm income (or loss), Schedule F	Counted	Line 18
Gifts or cash contributions	Not Counted	N/A
Government benefits (CalWORKs, Adoption/Foster Care assistance, disaster relief, relocation assistance)	Not Counted	N/A
In-kind income	Not Counted	N/A
Individual Retirement Account (IRA) distributions, 1099-R	Counted	Line 15b
Inheritance or taxable portion of inherited IRA or inherited pension	Not Counted	N/A
Interest income (taxable and tax exempt), 1099-INT	Counted	Line 8a and 8b
Interest income not received because the interest charged was below the applicable federal rate	Counted	Line 21
Loan proceeds	Not Counted	N/A
Lump sum income (Retroactive Social Security & Railroad Retirement benefits)	Counted as annual income	Line 20a and 20b
Lump sum received (Lottery winnings, cancellation of debt, surviving spouse receives salary or wages from decedent's spouse)	Counted as annual income	Line 21
Pensions, Department of Defense Retirement Board military retirement, endowment contracts paid as annuities, and taxable annuities	Counted	Line 16b
Rental real estate income (American Indian/Alaskan Native Exemptions), Schedule E	Counted	Line 17
Roth IRA, 401K, 403(b), or 457(b) Qualified Distribution	Not Counted	N/A
Royalties, partnerships, S-Corporations, trusts, etc. (or loss) [American Indian/Alaskan Native Exemptions], Schedule E	Counted	Line 17
Self-employment (in excess of expenses), Schedule K-1, Schedule SE	Counted	Line 21

Table 2-7: Counted and Not Counted Income Type

Type of Income	Counted/Not Counted	IRS 1040 Form
SSA Retirement, Survivors or Disability Benefits (Title II) (RSDI)	Counted	Line 20a and 20b
State Disability Insurance (SDI), **NOT** treated as unemployment benefits	Not Counted	N/A
State Disability Insurance (SDI), when treated as unemployment compensation, 1099-G	Counted	Line 19
Supplemental Security Income (SSI)/State Supplementary Payment (SSP) benefits	Not Counted	N/A
Tax Refund	Counted	Line 10
Unemployment Insurance Benefits (UIB)	Counted	Line 19
Veteran's service-related disability benefits, pension, annuity	Not Counted	N/A
Veteran's Administration education, training, or subsistence allowances	Not Counted	N/A
Work study income	Counted	N/A
Workers' Compensation	Not Counted	N/A

2.14.1 American Indian/Alaskan Native Income

Table 2-8: AI/AN Counted and Not Counted Income

Type of Income	Counted/Not Counted
Distributions from Alaska Native corporations and settlement trusts	Not Counted
Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior	Counted
Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from: • Rights of ownership or possession in any lands located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior • Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources	Counted

Table 2-8: AI/AN Counted and Not Counted Income

Type of Income	Counted/Not Counted
Distributions resulting from real property ownership interests related to natural resources and improvements: • Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or • Resulting from the exercise of federally-protected rights relating to such real property ownership interests	Counted
Payments resulting from ownership interest in or usage rights to items that have a unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom	Counted
Student financial aid provided under the Bureau of Indian Affairs education programs	Counted

2.15 Deductions

Deductions for APTC, CSR and QHP are based on tax rules. The allowable deductions appear on the 1040 form the client submits to the IRS.

Table 2-9: Income Deductions

Type of Deduction	Deducted/Not Deducted	IRS 1040 Form
Alimony paid	Deducted	Line 31a
Certain business expenses of reservists, performing artists, etc., Form 2106, 2061EZ	Deducted	Line 24
Child support paid	Not Deducted	N/A
Educator expenses	Deducted	Line 23
Deductible part of self-employment tax	Deducted	Line 27
Domestic production activities deductions	Deducted	Line 35
Health Savings Account (HSA)	Deducted	Line 29
IRA deduction	Deducted	Line 32
Moving expenses, Form 3903	Deducted	Line 26
Penalty on early savings withdrawal	Deducted	Line 30
Renter's credit (CA Tax Return), CA 540 - Line 46	Not Deducted	N/A

Table 2-9: Income Deductions

Type of Deduction	Deducted/Not Deducted	IRS 1040 Form
Self-employed health insurance deduction	Deducted	Line 29
Self-employment Simplified Employee Pension (SEP), Simple, and qualified plans, Form SE	Deducted	Line 28
Student loan interest paid	Deducted	Line 33
Tuition and fees, Form 8917	Deducted	Line 34

2.16 Budgeting

The budget for APTC, CSR and QHP includes all countable income and all allowable deductions, that number is then compared to the FPL rate for the household, based on tax filing household size.

2.16.1 Qualified Health Plan (QHP)

Applicants may choose to purchase an unsubsidized QHP through Covered CA at full cost to the client. When a client chooses not to request financial assistance on the application there is no MAGI MC, APTC, or CSR evaluation.

Likewise, applicants who do not file taxes in accordance with IRS law (i.e. those who are filing *Married Filing Separately* or those who received APTC last year but did not file taxes this year) are ineligible for APTC or CSR; however, they can purchase a qualified health plan for the full price.

2.16.2 Advanced Premium Tax Credit

Eligible applicants with income 139% to 400% FPL may be eligible for APTC. However, not all applicants under 400% FPL will receive a tax credit if the plan is considered affordable; the APTC will pay the gap between the full cost of the second-lowest Silver plan and the applicants' monthly maximum portion. [Refer to “Premiums,” page 2-37]

The individual or tax household income determines the APTC amount based on the FPL and family size. APTC allows the individual/tax household to reduce the cost for private health insurance plans purchased through Covered CA. The amount of APTC varies, with those who make less money getting a larger percentage of financial support to lower the cost of their insurance coverage.

To obtain APTC, applicants must enroll in a health plan through Covered CA during open enrollment (or special enrollment).

Example:

Joan makes $5,025/month and has two children who are both her tax dependents. Joan's income ($5,025) is 300% of the FPL for a family of 3. The income is within range for APTC.

2.16.3 Cost Sharing Reduction/Enhanced Silver Plan

In addition to APTC, eligible applicants with income 139% to 250% of the FPL may also receive CSR if they sign-up for the Silver plan, allowing the client to pay less out-of-pocket costs for health services (i.e. lower copayments). Applicants can only have CSR if they also have APTC; CSR cannot exist without APTC.

Applicants who meet the income requirements may be eligible for CSR. This benefit automatically applies if the client signs-up for a Silver plan.

The Cost Sharing Reduction/Enhanced Silver Plan Benefit chart identifies the income limits for CSR. There are three steps within this program: Silver 94, Silver 87, and Silver 73.

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Table 2-10: Cost Sharing Reduction/Enhanced Silver Plan Benefit

Number of People in the Household	Silver 94	Silver 87	Silver 73
1	$16,244 - $17,655	$17,656 - $23,540	$23,541 - $29,425
2	$21,984 - $23,895	$23,896 - $31,860	$31,861 - $39,825
3	$27,725 - $30,135	$30,136 - $40,180	$40,181 - $50,225
4	$33,466 - $36,375	$36,376 - $48,500	$48,501 - $60,625
5	$39,207 - $42,615	$42,616 - $56,820	$56,821 - $71,025

Within the CSR program, there are three steps: Silver 94, Silver 87 and Silver 73, the corresponding copayments and deductibles are listed below:

Table 2-11: Out-of-Pocket Costs - Cost Sharing Reduction/Enhanced Silver Plan Benefit

Key Benefits		Silver 94	Silver 87	Silver 73
Deductible (Medical Deductible)	Individual	$75	$550	$1,900
	Family	$150	$1,100	$3,800
Primary Care Visit Copayment		$5	$15	$40
Urgent Care Visit Copy		$6	$30	$80
Generic Medication Copayment		$3	$5	$15 or less
Drug Deductible	Individual	$0	$50	$250
	Family	$0	$100	$500
Emergency Room Copayment (Subject to Deductible)		$30	$75	$250
Annual Out-of-Pocket Maximum	Individual	$2,250	$2,250	$5,450
	Family	$4,500	$4,500	$10,900

2.17 APTC Budget in CalWIN

APTC budget information is located on the *APTC* tab of the **Display Health Care Financial Eligibility Results** window. The following is a description of the fields in CalWIN:

Table 2-12: CalWIN Fields on APTC Budget Tab

CalWIN Fields	Description
Income Deduction	Total amount of qualifying income deductions.
Total Monthly Income After Deduction	Monthly income after deductions.
Monthly APTC Amount	Tax credits used per month.

CalWIN Fields	Description
Max APTC Amount	Maximum monthly tax credits the household qualifies for.
FPL Percentage	The percentage of the FPL the income is.
APTC Aid Code	APTC aid code the individual qualifies for.
Start Date	The date coverage begins.
Contingent End Date	The date conditional eligibility ends if missing information is not provided.
Total Countable Income	Total countable monthly income less any deductions.
Total Annual Income After Deduction	Total countable annual income less any deductions.
Annual APTC Amounts	Maximum annual tax credits the household qualifies for.
FPL Limit	100% monthly FPL for household size.
Status	Eligibility status (i.e. Pass, Fail, Pending)
MFBU Size	Tax filing household size.
End Date	The date coverage ends.
Renewal Date	APTC renewal date in Covered CA.

2.18 Employer Sponsored Coverage

If a client's employer sponsored coverage is affordable, the client is not eligible for APTC. If an employer sponsored health plan covers the client (the employee) but not the family and is less than 9.5% of the family's income, the plan is considered affordable.

The client may pay more than 9.5% of the family's income on premiums for the spouse or family coverage, but affordability is determined by the amount the employee pays for self-only coverage from the employer. If the employee's coverage is less than 9.5% of the total family income, the spouse and dependent coverage are automatically determined affordable even if the family coverage is over 9.5% of the total income.

If the employee-only coverage is less than 9.5% of the family income, the family is not eligible for APTC.

2.19 CalHEERS

Covered CA certified plans are available in the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS). The Covered CA website (www.CoveredCA.com) allows clients to access online tools that help them compare coverage among the health plans, determine their eligibility, and enroll in coverage.

CalHEERS has the Business Rules Engine (BRE) to determine client eligibility for MAGI MC, APTC, CSR, or QHP. All MAGI MC eligibility determinations occur in CalHEERS, but CalWIN remains the system of record for all MC cases. Eligibility Workers (EWs) enter information into CalWIN which interfaces with CalHEERS via the Electronic Health Information Transfer (eHIT). Refer to the eHIT chapter.

CalHEERS validates information via the Federal Hub and sends a Determination Eligibility Response (DER) to the External Referral Subsystem in CalWIN with the healthcare application and eligibility information.

In certain situations, CalHEERS may approve MAGI MC eligibility and send eligibility directly to MEDS.

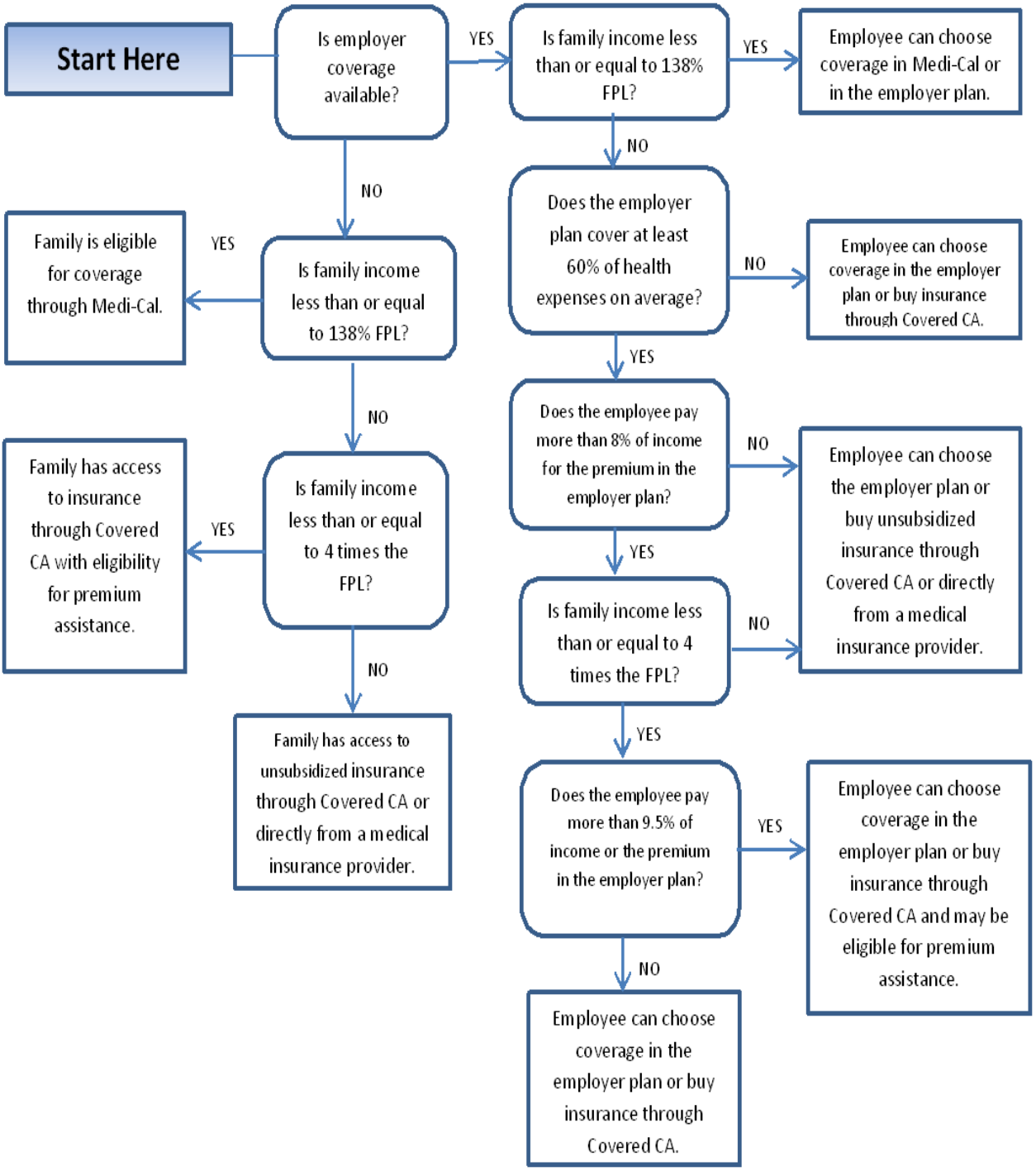
Note:

Even though this happens, EWs are still required to process the received External Referral Data (ERD) in the **Search for External Referral Data** window in CalWIN.

Example:

If a family completes an application in CalHEERS and all family members are determined eligible for MAGI MC and all information is verified via the Federal Hub, then CalHEERS will automatically send that information directly to MEDS in addition to the DER sent to CalWIN. Clerical staff completes application registration for the ERD and assigns it to the EW. The EW uploads the information into CalWIN.

2.20 Access to Health Coverage Work Flow



2.21 Plan Selection

Covered CA lists all eligible Covered CA Health Plans on the CalHEERS website. CalHEERS features a smart sort option, allowing applicants to answer three basic questions about what is most important to them (for example, a low monthly premium) and then CalHEERS finds and displays the plans that match.

CalHEERS comparison tools let clients compare options to find the coverage that meets both their health and budget needs.

The Plan Selection process is outlined in Job Aid: Covered California Plan Selection.

2.21.1 Health Plan Basics

All health plans have three elements:

- Covered services
- Premiums
- Out-of-pocket costs

Health insurance costs come from monthly premiums and the costs due when services are used.

2.21.2 Covered Services

Covered services (benefits) include physician visits, hospitalizations, and prescription drugs. All Covered CA Health Plans cover the 10 Minimum Essential Coverage services defined by the Affordable Care Act. While the coverage provided by all plans is the same, clients pay either lower monthly premiums or lower out-of-pocket costs depending on the metal tier the client selects.

2.21.3 Premiums

Several factors affect health plan premiums, including: plan design, geographic pricing regions, age, and income. Covered CA certified health plans must meet market-wide standards for coverage and accept all applicants regardless of health status.

Premium prices vary throughout the state; California has 19 geographic pricing regions. Premium rates increase with age, although never more than once a year. Health insurance companies must (1) justify premium increases and (2) spend a minimum of 80% of premium dollars on health care.

Insurance companies rate each family member individually. Health insurance companies charge for only the first three children under age 21 in a family; all children or dependents age 21 and older are charged a monthly premium based on their ages.

Example:

For a family of two adults and six children, both adults will be charged a monthly premium based on age but only 3 children will be charged a monthly premium.

The client's income determines the amount of APTC and eligibility for CSR. CalHEERS completes the following calculation to determine the APTC premium assistance amount:

Cost of the 2nd lowest Silver plan for the client
minus
Client’s required premium contribution amount
equals
APTC amount*
*If this is a negative number, then the client will be ineligible for APTC even with income below 400% FPL

2.21.4 Out-of-Pocket Costs/Cost Sharing

Out-of-pocket costs, also known as cost sharing, are the charges a client pays for services used which are not covered by insurance companies.

Out-of-pocket costs generally include:

- Coinsurance and copayments
- Deductibles

Out-of-pocket costs generally *do not* include:

- Premiums
- Balance Billing amount for out-of-network doctors and hospitals

Note:
Balance Billing is when a provider bills the client for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill the client for the remaining $30. A preferred provider may not ***balance bill*** a client for covered services.

- Costs of non-covered services

2.22 Comparing Plan Choices

Applicants will have many options to compare when shopping in the Covered CA marketplace.

Steps for selecting health insurance through Covered CA:

- Determine eligibility for APTC, CSR (Silver plans with better benefits), and/or MC
- Compare plans, networks, and prices (if enrolling in a Covered CA health plan)
    - Choose the plan category, taking into consideration how often the client will use healthcare services and the amount of out-of-pocket expenses versus monthly premiums.

- Select a health plan
  - Select the **Bronze, Silver, Gold** or **Platinum** metal tier.
  - Choose the preferred health plan available in the region.
- Enroll

Although an applicant is enrolled in a health plan, he/she must pay the monthly premiums to receive actual healthcare coverage.

2.22.1 Premiums vs. Out-of-Pocket Costs

An applicant needs to make the decision of higher premium and lower out-of-pocket cost or a lower premium and higher out-of-pocket cost. A plan that covers more of a person's healthcare costs and helps keep out-of-pocket costs low will have a higher monthly premium; this type of plan is more beneficial to applicants that plan on frequent doctor visits throughout the year. Whereas, a plan with a low monthly premium will have higher out-of-pocket costs (in copayments and deductibles) when and if services are used; this type of plan may be more beneficial to a client that does not intend on using the health services often throughout the year.

2.22.2 Plan Structure

Applicants signing-up for a QHP (unsubsidized coverage) have the flexibility to select one plan for all household members, choose a different plan for each member, or custom-group specific individuals in to a plan.

2.22.3 Doctor Selection

All health insurance companies offered through Covered CA have online network directories available on their websites. [Refer to “Provider Network Directories,” page 2-10]

HMO

Clients choose a PCP when they enroll for coverage. There is a place on the application to enter the doctor's name. If the client does not select a PCP when they enroll, the organization providing health coverage will assign one to them based on their address.

PPO, EPO, and other plans

Clients who select a PPO, EPO or other non-HMO plan can visit doctors or hospitals that are either in or out of the plan's network. Clients do not have to choose a doctor when they apply for coverage. However, the amount they will pay out of pocket may be lower if they use a doctor that is in-network.

2.23 Plan Enrollment

After enrollment into a Covered CA plan, the client becomes a member of the health plan selected. Each health insurance company may have differences in how and when they communicate with their new members. Generally, members receive a new member kit that provides an overview of how to navigate the plan. Members also receive several documents that should be kept for their record including:

Summary of Benefits

The *Summary of Benefits* helps consumers understand their coverage. It provides a description of coverage including any amounts the member has to pay (deductibles, coinsurance, and copayments).

ID Card

The ID Card provides important information:

- The health plan and health insurance company name
- The plan type and group or policy number
- The name of the primary care physician (for HMOs)
- Information for the doctors and hospitals
- Copay or coinsurance information

Evidence of Coverage

The *Evidence of Coverage* (EOC) is a contract between the client and the insurer. The EOC contains the following information:

- Details on what is covered under the client's policy, as well as any exclusions or limitations to coverage
- Benefit descriptions, premiums, and cost-sharing amounts
- Information on how to file a complaint or grievance
- Member rights and responsibilities
- Information on how to access care and services

Explanation of Benefits

After the client receives care from a doctor or hospital, the health insurance company sends an Explanation of Benefits (EOB). The EOB describes the payment between the health insurance company and the doctor, hospital or other provider of services. **The EOB is not a bill**. The client may receive a bill separately for any payment due directly to the doctor, hospital, or other provider (i.e. copays).

2.24 Changes

The client is required to report any changes in eligibility criteria. Changes may include:

- Add a household member (birth, adoption, marriage, etc.)
- Remove a household member
- Change in incarceration status
- Change in health coverage
- Change in citizenship/immigration status
- Change in household contact information
- Change in name
- Change in income (employment, self-employment, or other income)
- Change in deductions

- Tax information

Note:
Changes for APTC, CSR, and QHP should be reported within 30 days of the event.

2.25 Disenrollment

Termination may be voluntary or involuntary. Voluntary termination occurs when the client requests to discontinue coverage. Involuntary termination occurs when Covered CA or the health plan initiates termination. Following termination (voluntary or involuntary), the client will receive a notice of termination which describes the reason for the termination and information about the appeal process. The notification should occur at least 30 days prior to the last day of coverage.

2.25.1 Voluntary Disenrollment

Clients can request disenrollment if:

- The client obtains other coverage that meets the minimum essential coverage requirement.
- The client changes from one health plan to another during open enrollment or during a special enrollment period.

Clients should not disenroll until new coverage is active to avoid medical expenses between coverage.

2.25.2 Involuntary Disenrollment

Involuntary disenrollment may occur if:

- The client is no longer eligible for coverage under Covered CA (deceased, divorced, moved out of the service area, etc.)
- The client did not pay the premiums. The health plan will send the client a notice of delinquency if the client does not pay the plan premium.
- The client commits fraud.

- The QHP terminates or decertifies.

2.26 Tax Penalties

The IRS began imposing a share responsibility payment (tax penalty) during tax year 2014, for adults and children who do not meet MEC during the tax year. The tax filer receives tax penalties for all individuals in their tax filing household who do not have health coverage.

The tax penalty is either the percentage of total family income or the flat rate amount, whichever is the greater amount.

For the purpose of the tax penalty an adult is defined as an individual, age 18 years old or older, and a child (minor) is an individual under 18 years old.

Table 2-13: IRS Tax Penalties

Year	Percentage of Family Income	Set Dollar Penalty Amount
2014	1%	$95 per adult
		$47.50 per child (under age 18)
		Up to $285 per family
2015	2%	$325 per adult
		$162.50 per child (under age 18)
		Up to $975 per family
2016 and ongoing	2.5%	$695 per adult
		$347.50 per child (under age 18)
		Up to $2,085 per family

Clients are required to hold coverage for each month of the year; however, the law allows for a short coverage gap of less than three consecutive months. If more than one short coverage gap occurs during a calendar year, only the first is exempt from the tax penalty. If the coverage gap is 3 months or longer, none of the months in the gap qualifies for exemption.

Example:

Manny is uninsured. He starts a new job on March 15th and accepts his employer-sponsored health insurance which also begins in March. Manny is eligible for a short coverage gap exemption because the gap is less than three full calendar months (Jan. - Feb.).

Example:

Scarlett signs-up for coverage on January 31st, her coverage begins March 1st. Scarlett does not have coverage for January or February, but does have coverage for all other months in the year. Scarlett will not receive a tax penalty because she had one short coverage gap of only 2 months.

Example:

Shawn signs-up for coverage January 1st, his coverage begins February 1st. Shawn loses coverage for June but has a special enrollment and receives coverage in July. Shawn does not have coverage in January or June. Shawn will receive a penalty for June because he had two separate gaps and only the first is exempt.

2.26.1 Tax Penalty Formula

- Subtract the tax filing threshold for the tax filing household size from the tax filing household gross income.
- Multiply that number by 1%, 2%, or 2.5%, depending on the benefit year.
- Divide by 12. (This is the monthly penalty rate.)
- Multiply by the number of months without coverage.

- Add back the monthly penalty rate for any month subject to the short coverage exemption.

Estimated Shared Responsibility Payment or Tax Penalty Fee Formula

[((Household Income - Tax Filing Threshold) x 1%) / 12 months] x Number of months without coverage = Total payment

Subtract any months subject to the short coverage gap exemption (if 2 or less).

DO NOT GIVE TAX ADVICE

Example:

In 2014, Flavio, an unmarried individual with no dependents, does **not** have minimum essential coverage for January or February and again in June or July. Flavio's household income is $40,000 and his tax filing threshold is $10,150 (Single).

To determine his payment using the shared responsibility payment formula, subtract $10,150 from $40,000. The result is $29,850. One percent of $29,850 equals $298.50.

The gap in January and February is exempt as a short coverage gap.

The penalty for two months of no coverage in June and July is $49.75 [$298.50 divided by 12 equals $24.87 times 2 months (June and July)]. The flat rate in 2014 is $95.

Flavio's tax penalty for 2014 is the flat rate of $95 because it is greater than the 1% for June and July.

Example:

Roseann and Raymond are married and have two children under 18 years old. They do **not** have minimum essential coverage for any family member for any month during 2014 and no one in the family qualifies for an exemption. For 2014, their household income is $70,000 and their tax filing threshold is $20,300 (Married Filing Jointly).

To determine their payments using the shared responsibility payment formula, subtract $20,300 from $70,000. The result is $49,700. One percent (1%) of $49,700 equals $497. The flat rate in 2014 is $285 ($95 per adult and $47.50 per child).

Roseann and Raymond have a shared responsibility payment for 2014 of $497 (12 months of no coverage) because the percentage is greater than the flat rate.

Example:

Idelle, a single mother claiming one child on her taxes, had coverage in January, **no coverage** in February through May, and coverage again in June through October, and **no coverage** again November. For 2015, her income is $30,000 and tax filing threshold is $13,050 (Head of Household).

To determine her payment using the shared responsibility payment formula, subtract $13,050 from $30,000. The result is $16,950. Two percent (2%) of $16,950 equals $339.

The penalty for six months of no coverage is $169.50 ($339 divided by 12 is $28.25 times 6 months). The flat rate in 2015 is $487.50 ($325 per adult and $162.50 per child).

Idelle's tax penalty is the flat rate $487.50 because it is greater than $169.50.

Example:

Pamela files taxes as *Head of Household* for her family of 4. They had coverage all year until they lost it in November. They had no coverage in November or December.

Pamela's tax penalty is $0 because she had a stop coverage gap of only two months.

2.27 Covered CA Appeals Process

Individuals can file an appeal to the county's fair hearings unit or through Covered CA when they disagree with the:

- Eligibility determination.
- Amount of premium assistance or cost sharing reduction.
- Annual redetermination of eligibility.
- Denied eligibility for an exemption from the individual responsibility.

- Denied enrollment into a Covered CA health plan.
- Covered CA did not process your information in a timely manner.
- Covered CA stated that you were not a U.S. citizen or U.S. national or a lawfully present individual living in the United States.
- Covered CA stated that your application was incomplete.
- An individual does not have other health coverage (such as free Medi-Cal or employer-sponsored insurance) that prevents you from qualifying for insurance through Covered CA.
- Covered CA stated that you are not a California resident.
- Covered CA stated that you did not pay your premiums by your due date.

An individual can file an appeal by completing the Request for a State Fair Hearing to Appeal a Covered CA Eligibility Determination form.

Individuals have **90 calendar days** to submit an appeal to the county or Covered CA. Individuals can also file an appeal directly to the U.S. Department of Health and Human Services. Counties and Covered CA have 90 to 120 calendar days to review and resolve the appeal.