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## Part Three Nonfinancial eligibility requirements

### 15.00 Nonfinancial eligibility requirements, in general ([01/15/201707/30/2014](#), [GCR 16-09614-04](#))

This part catalogs the nonfinancial eligibility requirements that apply across all health benefits. The provisions that assign these requirements to a particular program or benefit are set forth in Part Two of this rule.

### 16.00 Social Security number ([01/15/201708/01/2016](#), [GCR 16-09616-02](#))

#### 16.01 Medicaid<sup>1</sup> ([01/15/201708/01/2016](#), [GCR 16-09616-02](#))

(a) In general

- (1) Except as provided in paragraph (b) of this subsection, as a condition of Medicaid eligibility, each individual (including children) seeking Medicaid must furnish their Social Security number.
- (2) AHS will advise the individual of:
  - (i) The statute or other authority under which it is requesting the individual's Social Security number; and
  - (ii) The uses that will be made of each Social Security number, including its use for verifying income, eligibility, and amount of medical assistance payments under §§ 53.00 through 56.00.
- (3) If an individual cannot recall their Social Security number or Social Security numbers or has not been issued a Social Security number, AHS will:
  - (i) Assist the individual in completing an application for a Social Security number;
  - (ii) Obtain evidence required under SSA regulations to establish the age, the citizenship or non-citizenship status, and the true identity of the individual; and
  - (iii) Either send the application to SSA or, if there is evidence that the individual has previously been issued a Social Security number, request SSA to furnish the

<sup>1</sup>42 CFR § 435.910.

	<p>number.</p> <p>(4) Services to an otherwise eligible individual will not be denied or delayed pending issuance or verification of the individual's Social Security number by SSA or if the individual meets one of the exceptions in paragraph (b) of this subsection.</p> <p>(5) The Social Security number furnished by an individual will be verified to insure the Social Security number was issued to that individual, and to determine whether any other Social Security numbers were issued to that individual. See § 55.02(a) for information on the verification process.</p>
(b) Exception	<p>(1) The requirement of paragraph (a)(1) of this subsection does not apply, and a Medicaid identification number will be given, to an individual who:</p> <p>(i) Is not eligible to receive a Social Security number;</p> <p>(ii) Does not have a Social Security number and may only be issued a Social Security number for a valid non-work reason in accordance with 20 CFR § 422.104; or</p> <p>(iii) Refuses to obtain a Social Security number because of well-established religious objections. The term "well-established religious objections" means that the individual is a member of a recognized religious sect or division of the sect, and adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number including a Social Security number.</p> <p>(2) The Medicaid identification number may be either a Social Security number obtained on the individual's behalf or another unique identifier.</p> <p>(3) An individual who has a Social Security number is not subject to this exception and must provide such number.</p>
(c) Social Security numbers of Medicaid non-applicants <sup>2</sup>	<p>AHS may request the Social Security number of a person who is not applying for Medicaid for themselves provided that:</p> <p>(1) Provision of such Social Security number is voluntary;</p> <p>(2) Such Social Security number is used only to determine an applicant's or enrollee's eligibility for a health-benefits program or for a purpose directly connected to the administration of the</p>

<sup>2</sup> 42 CFR § 435.907(e)(3).

	<p>state plan; and</p> <p>(3) At the time such Social Security number is requested, AHS provides clear notice to the individual seeking assistance, or person acting on such individual's behalf, that provision of the non-applicant's Social Security number is voluntary and information regarding how the Social Security number will be used.</p>
<p><b>16.02 QHP<sup>3</sup> (<a href="#">01/15/201708/01/2016</a>, <a href="#">GCR 16-09616-02</a>)</b></p>	
	<p>(a) An individual applying for a QHP, with or without APTC or CSR, and who has a Social Security number must provide it. The number provided will be verified by AHS. See § 55.02(a) for information on the verification process.</p> <p>(b) Except as provided in paragraph (c) of this subsection, a person who is not seeking coverage for themselves need not provide a Social Security number.</p> <p>(c) An application filer seeking APTC must provide the Social Security number of a tax filer who is not an applicant only if an applicant attests that the tax filer has a Social Security number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size.<sup>4</sup></p>
<p><b>17.00 Citizenship and immigration status<sup>5</sup> (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b></p>	
<p><b>17.01 Definitions (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b></p>	
(a) U.S. Citizen	<p>(1) An individual born in the 50 states, the District of Columbia, Puerto Rico, Guam, Virgin Islands, and the Northern Mariana Islands (except for individuals born to foreign diplomats);</p> <p>(2) A naturalized citizen; or</p> <p>(3) An individual who otherwise qualifies for U.S. citizenship under § 301 of the Immigration and Nationality Act (INA), 8 USC §§ 1401.</p>

<sup>3</sup> 45 CFR § 155.310(a)(3).

<sup>4</sup> 45 CFR § 155.305(f)(6).

<sup>5</sup> This section establishes the health-benefits citizenship and immigration-status eligibility requirements. Rules covering the related attestation and verification requirements and outlining documentary evidence are set forth in § 54.00.

(b) Citizenship <sup>6</sup>	Includes status as a “national of the United States” that includes both citizens of the United States and non-citizen nationals of the United States.
(c) National <sup>7</sup>	<p>(1) An individual who:</p> <ul style="list-style-type: none"> <li>(i) Is a U.S. citizen; or</li> <li>(ii) Though not a citizen, owes permanent allegiance to the United States.</li> </ul> <p>(2) For purposes of determining health-benefits eligibility, including verification requirements, citizens and non-citizen nationals of the United States are treated the same.</p> <p>(3) As a practical matter, non-citizen nationals include individuals born in American Samoa or Swains Island.</p>
(d) Qualified non-citizen <sup>8</sup>	<p>An individual who is:</p> <ul style="list-style-type: none"> <li>(1) A lawful, permanent resident of the United States (LPR);</li> <li>(2) A refugee, including: <ul style="list-style-type: none"> <li>(i) An individual admitted to the United States under § 207 of the INA;</li> <li>(ii) A Cuban or Haitian entrant, as defined in § 501(e)(2) of the Refugee Education Assistance Act of 1980. There are three general categories of individuals who are considered “Cuban and Haitian entrants.” A Haitian national meets the definition of “Cuban and Haitian entrant” if he or she: <ul style="list-style-type: none"> <li>(A) Was granted parole status as a Cuban/Haitian entrant (Status Pending) on or after April 21, 1980 or has been paroled into the United States on or after October 10, 1980;</li> <li>(B) Is the subject of removal, deportation or exclusion proceedings under the Immigration and Nationality Act and with respect to whom a final, nonappealable, and legally enforceable order of removal, deportation or exclusion has not been entered; or</li> </ul> </li> </ul> </li> </ul>

<sup>6</sup> 42 CFR § 435.4 (NPRM, 78 FR 4593).

<sup>7</sup> 8 USC § 1101(a)(22).

<sup>8</sup> 42 CFR § 435.4 (NPRM, 78 FR 4593) (“qualified non-citizen” has the same meaning as the term “qualified alien” as defined at 8 USC § 1641(b) and (c)); 42 USC § 435.406(a)(2).

	<p>(C) Has an application for asylum pending with the Department of Homeland Security (DHS) and with respect to whom a final, nonappealable, and legally enforceable order of removal, deportation or exclusion has not been entered.</p> <p>(3) An Amerasian, admitted to the United States under § 584 of the Foreign Operations Export Financing, and Related Programs Appropriation Act, 1988 (as contained in § 101(e) of Public Law 100-202 and amended by the 9th proviso under Migration and Refugee Assistance in title II of the Foreign Operations Export Financing, and Related Programs Act, 1989, Public Law 100-461, as amended);</p> <p>(4) An asylee, as defined in § 208 of the INA;</p> <p>(5) A non-citizen whose deportation has been withheld under:</p> <p>(i) § 243(h) of the INA, as in effect prior to April 1, 1997, (the effective date of § 307 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), division C of Public Law 104-208); or</p> <p>(ii) § 241(b)(3) of the INA, as amended by § 305(a) of division C of Public Law 104-208;</p> <p>(6) An non-citizen who has been granted parole for at least one year by the USCIS under § 212(d)(5) of the INA;</p> <p>(7) A non-citizen who has been granted conditional entry under § 203(a)(7) of the INA;</p> <p>(8) A battered non-citizen, as defined in paragraph (e) of this subsection;</p> <p>(9) A victim of a severe form of trafficking, in accordance with § 107(b)(1) of the Trafficking Victims Protection Act of 2000; or</p> <p>(10) An American Indian, born outside the U.S. and who enters and re-enters and resides in the U.S. is, for Medicaid purposes, considered a lawful permanent resident and, as such, a qualified non-citizen. This includes:</p> <p>(i) An American Indian who was born in Canada and who is of at least one-half American Indian blood. This does not include the non-citizen spouse or child of such an Indian or a non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50% American Indian blood.</p> <p>(ii) An American Indian who is a member of a Federally-recognized Indian tribe, as defined in § 4(e) of the Indian Self-Determination and Education Assistance Act, 25 USC</p>
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	§ § 450b(e). <sup>9</sup>
(e) Battered non-citizen	<p>(1) An individual who is:</p> <ul style="list-style-type: none"> <li>(i) A victim of battering or cruelty by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the victim and the spouse or parent consented to, or acquiesced in the battery or cruelty;</li> <li>(ii) The parent of a child who has been such a victim, provided that the individual did not actively participate in the battery or cruelty; or</li> <li>(iii) The child residing in the same household of such a victim.</li> </ul> <p>(2) For the purposes of establishing qualified non-citizen status, the battered non-citizen must meet all of the following conditions:</p> <ul style="list-style-type: none"> <li>(i) The individual must no longer be residing in the same household as the perpetrator of the abuse or cruelty;</li> <li>(ii) The battery or cruelty must have a substantial connection with the need for medical assistance; and</li> <li>(iii) The individual must have been approved for legal immigration status, or have a petition pending that makes a prima facie case for legal immigration status, under one of the following categories: <ul style="list-style-type: none"> <li>(A) Permanent residence under the Violence Against Women Act (VAWA);</li> <li>(B) A pending or approved petition for legal permanent residence filed by a spouse or parent on USCIS Form I-130 or Form I-129f; or</li> <li>(C) Suspension of deportation or cancellation of removal under VAWA.</li> </ul> </li> </ul>
(f) Nonqualified non-citizen	A non-citizen who does not meet the definition of qualified non-citizen (§17.01(d)).
(g) Lawfully present in the United States	<p>An individual who is a non-citizen and who:</p> <ul style="list-style-type: none"> <li>(1) Is a qualified non-citizen, as defined in paragraph (d) of this subsection;</li> <li>(2) Is in a valid nonimmigrant status, as defined in 8 USC § 1101(a)(15) or otherwise under the immigration laws (as</li> </ul>

<sup>9</sup> Abenaki is not a federally-recognized tribe.

	<p>defined in 8 USC § 1101(a)(17));</p> <p>(3) Is paroled into the United States in accordance with 8 USC § 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;</p> <p>(4) Belongs to one of the following classes:</p> <ul style="list-style-type: none"> <li>(i) Granted temporary resident status in accordance with 8 USC § 1160 or 1255a, respectively;</li> <li>(ii) Granted Temporary Protected Status (TPS) in accordance with 8 USC § 1254a, and individuals with pending applications for TPS who have been granted employment authorization;</li> <li>(iii) Granted employment authorization under 8 CFR § 274a.12(c);</li> <li>(iv) Family Unity beneficiaries in accordance with § 301 of 101, as amended;</li> <li>(v) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;</li> <li>(vi) Granted Deferred Action status;</li> <li>(vii) Granted an administrative stay of removal under 8 CFR part 241;</li> <li>(viii) Beneficiary of approved visa petition who has a pending application for adjustment of status;</li> </ul> <p>(5) Is an individual with a pending application for asylum under 8 USC § 1158, or for withholding of removal under 8 USC § 1231, or under the Convention Against Torture who—</p> <ul style="list-style-type: none"> <li>(i) Has been granted employment authorization; or</li> <li>(ii) Is under the age of 14 and has had an application pending for at least 180 days;</li> </ul> <p>(6) Has been granted withholding of removal under the Convention Against Torture;</p> <p>(7) Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 USC § 1101(a)(27)(J);</p> <p>(8) Is lawfully present in American Samoa under the immigration laws of American Samoa; or</p>
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	<p>(9) Is a victim of a severe form of trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Public Law 106-386, as amended (22 USC § 7105(b)).</p> <p>(10) <i>Exception.</i> An individual with deferred action under DHS's deferred action for childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012, memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.</p>
(h) Non-citizen <sup>10</sup>	Has the same meaning as the term "alien," as defined in section 101(a)(3) of the INA, (8 USC § 1101(a)(3)) and includes any individual who is not a citizen or national of the United States, defined at 8 USC § 1101(a)(22).
<b>17.02 General Rules (<a href="#">01/15/2017/07/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
(a) Health benefits, in general	Except as provided in paragraphs (b) through (d) of this subsection, as a condition of eligibility for health benefits, an individual must be a citizen or national of the United States and, for purposes of enrollment in a QHP, must reasonably expect to be a citizen or national for the entire period for which QHP enrollment is sought.
(b) Enrollment in Medicaid	<p>An individual who is a non-citizen is eligible for Medicaid if the individual otherwise satisfies the eligibility requirements and is:</p> <p>(1) A qualified non-citizen who is not subject to the five-year bar under § 17.03(b); or</p> <p>(2) A non-citizen who is not subject to the five-year bar under § 17.03(c).</p>
(c) Enrollment in a QHP, with or without APTC or CSR	An individual who is a non-citizen who is lawfully present in the United States is eligible for enrollment in a QHP, with or without APTC or CSR, if the individual otherwise satisfies the eligibility requirements for a QHP and is reasonably expected to be a non-citizen who is lawfully present for the entire period for which QHP enrollment is sought.
(d) Emergency medical services <sup>11</sup>	<p>An individual who is ineligible for Medicaid solely because of immigration status is eligible for the treatment of emergency medical conditions if all of the following conditions are met:</p> <p>(1) The individual has, after sudden onset, a medical condition</p>

<sup>10</sup> 42 CFR § 435.4 (NPRM, 78 FR 4593).

<sup>11</sup> A legally-present individual who is enrolled in a QHP, with or without subsidies, is nevertheless eligible for emergency Medicaid. See CMS Response to Comment, 77 FR 17144, 17170.

	<p>(including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in serious:</p> <ul style="list-style-type: none"> <li>(i) Jeopardy to the individual's health;</li> <li>(ii) Impairment of bodily functions; or</li> <li>(iii) Dysfunction of any bodily organ or part.</li> </ul> <p>(2) The individual meets all eligibility requirements for Medicaid except that non-qualified non-citizens need not present a Social Security number or document immigration status.</p> <p>(3) Emergency medical services do not include organ transplant procedures or routine prenatal or post partum care.</p>
<p><b>17.03 Medicaid five-year bar for qualified non-citizens</b>  <b>(<a href="#">01/15/2017</a>/<a href="#">07/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b></p>	
<p>(a) Qualified non-citizens subject to 5-year bar<sup>12</sup></p>	<p>Non-citizens who enter the United States on or after August 22, 1996, as qualified non-citizens are not eligible to receive Medicaid for five years from the date they enter the country. If they are not qualified non-citizens when they enter, the five-year bar begins the date they become a qualified non-citizen. The following qualified non-citizens are subject to the five-year bar:</p> <ul style="list-style-type: none"> <li>(1) Lawful permanent residents (LPRs);</li> <li>(2) Non-citizens granted parole for at least one year;</li> <li>(3) Non-citizens granted conditional entry (however, as a practical matter the five-year bar will never apply to such non-citizens, since, by definition, they entered the U.S. and obtained qualified non-citizen status prior to August 22, 1996); and</li> <li>(4) Battered non-citizens.</li> </ul>
<p>(b) Qualified non-citizens not subject to 5-year bar<sup>13</sup></p>	<p>The following qualified non-citizens are not subject to the five-year bar:</p> <ul style="list-style-type: none"> <li>(1) Refugees;</li> </ul>

<sup>12</sup> 42 CFR § 435.406(a)(2); 8 USC § § 1613(a).

<sup>13</sup> 42 CFR § 435.406(a)(2); 8 USC § § 1613(b).

	<ul style="list-style-type: none"> <li>(2) Asylees;</li> <li>(3) Cuban and Haitian Entrants;<sup>14</sup></li> <li>(4) Victims of a severe form of trafficking;</li> <li>(5) Non-citizens whose deportation is being withheld;</li> <li>(6) Qualified non-citizens who are: <ul style="list-style-type: none"> <li>(i) Honorably discharged veterans;</li> <li>(ii) On active duty in the U.S. military; or</li> <li>(iii) The spouse (including a surviving spouse who has not remarried) or unmarried dependent child of an honorably discharged veteran or individual on active duty in the U.S. Military;</li> </ul> </li> <li>(7) Non-citizens admitted to the country as Amerasian immigrants;</li> <li>(8) Legal permanent residents who first entered the United States under another exempt category (i.e., as a refugee, asylee, Cuban or Haitian entrant, trafficking victim, or non-citizen whose deportation was being withheld) and who later converted to the LPR status.</li> <li>(9) Haitians granted Humanitarian Parole status; and</li> <li>(10) Citizens and nationals of Iraq and Afghanistan with Special Immigrant status.<sup>15</sup></li> </ul>
(c) Non-citizens not subject to 5-year bar <sup>16</sup>	<p>The five-year bar does not apply to:</p> <ul style="list-style-type: none"> <li>(1) Non-citizens who are applying for treatment of an emergency medical condition only;</li> <li>(2) Non-citizens who entered the United States and became qualified non-citizens prior to August 22, 1996; and</li> <li>(3) Non-citizens who entered prior to August 22, 1996, and remained “continuously present” in the United States until</li> </ul>

<sup>14</sup> From former PP&D at 4172.

<sup>15</sup> From former PP&D at 4173.

<sup>16</sup> Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title IV of the Personal Responsibility and Work Opportunity Act of 1996; 62 Federal Register 61344 and 61415 (November 17, 1997).

	<p>becoming a qualified non-citizen on or after that date. Any single absence of more than 30 consecutive days or a combined total absence of 90 days before obtaining qualified non-citizen status is considered to interrupt “continuous presence.”</p> <ul style="list-style-type: none"> <li>(i) Non-citizens who do not meet “continuous presence” are subject to the five-year bar beginning from the date they become a qualified non-citizen.</li> <li>(ii) Non-citizens do not have to remain continuously present in the United States after obtaining qualified non-citizen status.</li> </ul> <p>(4) Members of a Federally-recognized Indian tribe;</p> <p>(5) American Indians born in Canada to whom § 289 of the INA applies; and</p> <p>(6) Children up to 21 years of age and women during pregnancy and the 60-day postpartum period, who are lawfully residing in the United States and otherwise eligible. AHS will verify that the child or pregnant woman is lawfully residing in the United States at the time of the individual’s initial eligibility determination and at the time of eligibility redeterminations. A child or pregnant woman will be considered to be lawfully residing in the United States if they are:</p> <ul style="list-style-type: none"> <li>(i) A qualified non-citizen as defined in § 431 of PRWORA (8 USC § 1641)(see 17.01(d));</li> <li>(ii) A non-citizen in non-immigration status who has not violated the terms of the status under which they were admitted or to which they have changed after admission;</li> <li>(iii) A non-citizen who has been paroled into the United States pursuant to § 212(d)(5) of the INA (8 USC § 1182(d)(5)) for less than 1 year, except for a non-citizen paroled for prosecution, for deferred inspection or pending removal proceedings;</li> <li>(iv) A non-citizen who belongs to one of the following classes: <ul style="list-style-type: none"> <li>(A) Non-citizens currently in temporary resident status pursuant to § 210 or 245A of the INA (8 USC § 1160 or 1255a, respectively);</li> <li>(B) Non-citizens currently under Temporary Protected Status (TPS) pursuant to § 244 of the INA (8 USC § 1254a), and pending applicants for TPS who have been granted employment authorization;</li> <li>(C) Non-citizens who have been granted employment</li> </ul> </li> </ul>
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	<p>authorization under 8 CFR § 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);</p> <p>(D) Family Unity beneficiaries pursuant to § 301 of Pub. L. 101-649, as amended;</p> <p>(E) Non-citizens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;</p> <p>(F) Non-citizens currently in deferred action status; or</p> <p>(G) Non-citizens whose visa petitions have been approved and who have pending applications for adjustment of status;</p> <p>(v) A pending applicant for asylum under § 208(a) of the INA (8 USC § 1158) or for withholding of removal under § 241(b)(3) of the INA (8 USC § 1231) or under the convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;</p> <p>(vi) A non-citizen who has been granted withholding of removal under the Convention Against Torture; or</p> <p>(vii) A child who has a pending application for Special Immigrant Juvenile status as described in § 101(a)(27)(J) of the INA (8 USC § 1101(a)(27)(J)).</p>
(d) Ineligible non-citizens/nonimmigrants	<p>The following categories of individuals are ineligible non-citizens/non-immigrants and are not eligible for Medicaid:</p> <p>(1) Foreign government representatives on official business and their families and servants;</p> <p>(2) Visitors for business or pleasure, including exchange visitors;</p> <p>(3) Non-citizens in travel status while traveling directly through the U.S.;</p> <p>(4) Crewmen on shore leave;</p> <p>(5) Foreign students;</p> <p>(6) International organization representation personnel and their families and servants;</p> <p>(7) Temporary workers including agricultural contract workers; and</p> <p>(8) Members of foreign press, radio, film, or other information</p>

	media and their families.
<b>18.00 Assignment of rights and cooperation requirements for Medicaid</b> ( <a href="#">01/15/201707/30/2014</a> , <a href="#">GCR 16-09614-04</a> )	
<b>18.01 In general</b> <sup>17</sup> ( <a href="#">01/15/201707/30/2014</a> , <a href="#">GCR 16-09614-04</a> )	
	As a condition of initial and continuing eligibility, a legally-able individual who is applying for or enrolled in Medicaid must meet the requirements related to the pursuit of medical support, third-party payments, and the requirement to enroll or remain enrolled in a group health insurance plan, as provided for below.
<b>18.02 Assignment of rights to payments</b> ( <a href="#">01/15/201707/30/2014</a> , <a href="#">GCR 16-09614-04</a> )	
(a) In general	An individual who is applying for, or enrolled in Medicaid, with the legal authority to do so, must assign their rights to medical support and third-party payments for medical care. If they have the legal authority to do so, they must also assign the rights of any other individual who is applying for or enrolled in Medicaid to such support and payments.
(b) Exceptions	No assignment is required for: <ul style="list-style-type: none"> <li>(1) Medicare payments; or</li> <li>(2) Cash payments from the Department of Veterans Affairs for aid and attendance.</li> </ul>
<b>18.03 Cooperation in Obtaining Payments</b> ( <a href="#">01/15/201707/30/2014</a> , <a href="#">GCR 16-09614-04</a> )	
(a) In general	<ul style="list-style-type: none"> <li>(1) Applicants must attest that they will cooperate, and enrollees must cooperate in: <ul style="list-style-type: none"> <li>(i) Establishing paternity and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating as described in § 18.04; and</li> <li>(ii) Identifying and providing information to assist in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating as described in § 18.04.</li> </ul> </li> <li>(2) To meet this requirement, an individual may be required to: <ul style="list-style-type: none"> <li>(i) Provide information or evidence relevant and essential to</li> </ul> </li> </ul>

<sup>17</sup> 42 CFR § 435.610; Former Medicaid Rules 4138-4138.4.

	<p>obtain such support or payments;</p> <p>(ii) Appear as a witness in court or at another proceeding;</p> <p>(iii) Provide information or attest to lack of information under penalty of perjury; or</p> <p>(iv) Take any other reasonable steps necessary for establishing parentage or securing medical support or third-party payments.</p>
(b) Exception	An unmarried pregnant woman with income under 208 percent of the FPL is exempted from the requirement to cooperate in establishing paternity or obtaining medical support and payments from, or derived from, the father of the child she expects to deliver or from the father of any of her children born out-of-wedlock. She shall remain exempt through the end of the calendar month in which the 60-day period beginning with the date of her delivery ends.
<b>18.04 Good cause for noncooperation (<a href="#">01/15/2017</a><a href="#">07/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
(a) In general	<p>An individual who is applying for or enrolled in Medicaid may request a waiver of the cooperation requirement under § 18.03. Those to whom a good-cause waiver for noncooperation has been granted are eligible for Medicaid, provided that all other program requirements are met. AHS will grant such waivers when either of the following circumstances has been substantiated to AHS's satisfaction:</p> <p>(1) Compliance with the cooperation requirement is reasonably anticipated to result in physical or emotional harm to the individual responsible for cooperating or the person for whom medical support or third-party payments are sought. Emotional harm means an emotional impairment that substantially affects an individual's functioning; or</p> <p>(2) Compliance with the cooperation requirement would entail pursuit of medical support for a child:</p> <p>(i) Conceived as a result of incest or rape from the father of that child;</p> <p>(ii) For whom adoption proceedings are pending; or</p> <p>(iii) For whom adoptive placement is under active consideration.</p>
(b) Required documentation	An Individual requesting a waiver of the cooperation requirement bears the primary responsibility for providing the documentation AHS deems necessary to substantiate their claims of good cause. AHS will consider an individual who has requested a good-cause waiver and submitted the required documentation to be eligible for Medicaid while a decision

	on the request is pending.
(c) Review of good-cause waiver	A review of the continued existence of good cause circumstances upon which a waiver has been granted is required no less frequently than at each redetermination of eligibility for those cases in which determination of good cause is based on a circumstance that may change. A formal decision based upon resubmission of evidence is not required, however, unless AHS determines that a significant change of circumstances relative to good cause has occurred.
<b>18.05 Enrollment in a health insurance plan (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
	<p>(a) An individual who is applying for, or enrolled in Medicaid, may be required to enroll or remain enrolled in a group health insurance plan for which AHS pays the premiums. (See Medicaid Covered Services Rule (MCSR) 7108.) Payment of group health insurance premiums shall be made only under the conditions specified in this subsection and in MCSR 7108.1 and remain entirely at AHS's discretion. Such payment of premiums shall not be considered an entitlement for any individual.</p> <p>(b) As a condition of continuing eligibility, an individual may be required to remain enrolled in an individual health insurance plan, provided that they are enrolled in a plan for which the state has been paying the premiums on a continuous basis since July 2000.</p> <p>(c) For the purposes of this subsection and MCSR 7108.1, a group health insurance plan is a plan that meets the definition of a group health insurance plan specified in 8 V.S.A. § 4079. An individual health insurance plan is a plan that does not meet that definition.</p>
<b>19.00 Incarceration and QHP eligibility (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
<b>19.01 In general<sup>18</sup> (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
	An incarcerated individual, other than an individual who is incarcerated pending the disposition of charges, is ineligible for enrollment in a QHP.
<b>19.02 Exception<sup>19</sup> (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
	An incarcerated individual may be an applicable tax filer if a family

<sup>18</sup> 26 CFR § 1.36B-2(a)(4); 45 CFR § 155.305(a)(2).

<sup>19</sup> 26 CFR § 1.36B-2(a)(4); See §§ 1312(f)(1)(B) and 1312(f)(3) of the ACA (42 USC § 18032(f)(1)(B) and (f)(3)) and 26 CFR § 1.36B-3(b)(2).

	member is eligible to enroll in a QHP.
<b>20.00 Living arrangements for Medicaid eligibility purposes</b> <b>(<a href="#">01/15/2017</a><del>07/30/2014</del>, <a href="#">GCR 16-09614-04</a>)</b>	
<b>20.01 In general<sup>20</sup> (<a href="#">01/15/2017</a><del>07/30/2014</del>, <a href="#">GCR 16-09614-04</a>)</b>	
	<p>Individuals or couples meet the living-arrangement requirement for Medicaid eligibility purposes if they live in:</p> <ul style="list-style-type: none"> <li>(a) Their own home;</li> <li>(b) The household of another; or</li> <li>(c) The following public institutions: <ul style="list-style-type: none"> <li>(1) The Vermont State Hospital (VSH) or successor entity or entities, if the individual is: <ul style="list-style-type: none"> <li>(i) Under the age of 21 (if a Medicaid enrollee is a patient of VSH upon reaching their 21st birthday, eligibility may be continued to the date of discharge or their 22nd birthday, whichever comes first, upon a finding by the VSH Disability Determination Team that the individual is blind or disabled according to SSI/AABD standards); or</li> <li>(ii) Age 65 or older.</li> </ul> </li> <li>(2) An intermediate care facility for people with developmental disabilities (ICF-DD).</li> <li>(3) A facility supported in whole or in part by public funds whose primary purpose is to provide medical care other than the treatment of mental disease, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.</li> </ul> </li> <li>(d) A private facility, if: <ul style="list-style-type: none"> <li>(1) The primary purpose of the facility is to provide medical care other than the treatment of mental diseases, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.; and</li> <li>(2) The facility meets the following criteria: <ul style="list-style-type: none"> <li>(i) There is no agreement or contract obliging the institution to</li> </ul> </li> </ul> </li> </ul>

<sup>20</sup> Former Medicaid Rules 4218 and 4332

	<p>provide total support to the individual;</p> <p>(ii) There has been no transfer of property to the institution by the individual or on their behalf, unless maintenance by the institution has been of sufficient duration to fully exhaust the individual's equity in the property transferred at a rate equal to the monthly charges to other residents in the institution; and</p> <p>(iii) There is no restriction on the individual's freedom to leave the institution.</p> <p>(3) An individual under the age of 21 or age 65 or older meets the living arrangement requirement if they live at the Brattleboro Retreat. In addition, an individual who is a patient at the facility upon reaching their 21st birthday, has eligibility continued to the date of discharge (or end of ten day notice period, if later) or their 22nd birthday, whichever comes first, as long as they continue to meet all other eligibility requirements.</p>
<p><b>20.02 Correctional facility (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b></p>	
(a) In general <sup>21</sup>	An individual living in a correctional facility, including a juvenile facility, is not eligible for Medicaid.
(b) Determination of incarceration	Incarceration begins on the date of admission and ends when the individual moves out of the correctional facility.
(c) Exception: Transfer to a medical facility <sup>22</sup>	While incarcerated, Medicaid is available when the inmate is an inpatient in a medical institution not under the control of the corrections system. Such institutions include a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility.
(d) Affect of incarceration on enrollment	Once determined Medicaid eligible, an individual who is incarcerated retains eligibility. However, their case is placed in suspended status during the period of incarceration.
<p><b>20.03 Determination of residence in an institution (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b></p>	
	Residence in an institution is determined by the dates of admission and discharge. An individual at home in the community on a visiting pass is still a resident of the institution.

<sup>21</sup> 42 CFR §§ 435.1009 and 435.1010.

<sup>22</sup> 42 CFR §§ 435.1009 and 435.1010. This is also based on various letters from CMS to states, inquiring about the availability of federal funds participation for inmate inpatient health care.

<b>20.04 Homeless individuals (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
	A homeless individual is considered to be living in their own home.
<b>20.05 Financial responsibility and living arrangement (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
	The financial responsibility of relatives varies depending upon the type of living arrangement.
<b>21.00 Residency (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
<b>21.01 In general<sup>23</sup> (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
	AHS will provide health benefits to an eligible Vermont resident.
<b>21.02 Incapability of indicating intent (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
	For purposes of this section, an individual is considered incapable of indicating intent regarding residency if the individual: <ul style="list-style-type: none"> <li>(a) Has an I.Q. of 49 or less or has a mental age of 7 years or less, based on tests acceptable to AHS;</li> <li>(b) Is judged legally incompetent; or</li> <li>(c) Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the state in the field of intellectual disabilities.</li> </ul>
<b>21.03 Who is a state resident (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
	A resident of the state is any individual who: <ul style="list-style-type: none"> <li>(a) Meets the conditions in §§ 21.04 through 21.08; or</li> <li>(b) Meets the criteria specified in an interstate agreement under § 21.10.</li> </ul>
<b>21.04 Placement by a state in an out-of-state institution<sup>24</sup></b>	

<sup>23</sup> 42 CFR § 435.403; 45 CFR § 155.305(a)(3). Note: The Exchange rules speak in terms of residence within the Exchange's "service area." However, as there will be a single "service area" in Vermont, for both Medicaid and QHP enrollment, this rule speaks in terms of residence within the state.

<sup>24</sup> 42 CFR § 435.403(e).

**(01/15/2017/07/30/2014, GCR 16-09614-04)**

- (a) Any state agency, including an entity recognized under state law as being under contract with the state for such purposes, that arranges for an individual to be placed in an institution located in another state is recognized as acting on behalf of the state in making a placement. The state arranging or actually making the placement is considered as the individual's state of residence.
- (b) Any action beyond providing information to the individual and the individual's family would constitute arranging or making a state placement. However, the following actions do not constitute state placement:
  - (1) Providing basic information to individuals about another state's Medicaid program and information about the availability of health care services and facilities in another state.
  - (2) Assisting an individual in locating an institution in another state, provided the individual is capable of indicating intent and independently decides to move.
  - (3) When a competent individual leaves the facility in which the individual is placed by a state, that individual's state of residence for Medicaid purposes is the state where the individual is physically located.
  - (4) Where a placement is initiated by a state because the state lacks a sufficient number of appropriate facilities to provide services to its residents, the state making the placement is the individual's state of residence.

**21.05 An individual receiving Aid to the Aged, Blind, and Disabled (AABD)<sup>25</sup>**  
**(01/15/2017/07/30/2014, GCR 16-09614-04)**

(a) In general	For an individual of any age who is receiving a state supplemental payment (in Vermont, known as AABD), the state of residence is the state paying the state supplemental payment.
(b) Exception <sup>26</sup>	A transient worker may claim Vermont as their state of residence and be granted Medicaid if they meet all other eligibility criteria. These

<sup>25</sup> Effective January 1, 1974, the major portion of Vermont's federal-state program of AABD became the federal program of Supplemental Security Income (SSI) through amendment of title XVI of the Social Security Act. SSI guarantees a minimum national standard of assistance to aged, blind or disabled persons at full federal expense. Vermont supplements the SSI payment with a state-funded payment. While, federal government abandoned the AABD program title, Vermont has retained this name for this state supplementary payment. See, AABD Rule 2700.

<sup>26</sup> Former Medicaid Rule 4217(A).

	individuals may be granted Vermont Medicaid even though they continue to receive a state supplement payment from another state.
<b>21.06 An individual age 21 and over<sup>27</sup> (<a href="#">01/15/2017</a><del>07/30/2014</del>, <a href="#">GCR 16-09614-04</a>)</b>	
	<p>Except as provided in § 21.05, with respect to individuals age 21 and over:</p> <p>(a) For an individual not residing in an institution, as defined in § 3.00, including a licensed foster care providing food, shelter, and supportive services to one or more persons unrelated to the proprietor, the state of residence is the state where the individual is living and:</p> <ol style="list-style-type: none"> <li>(1) Intends to reside, including without a fixed address; or</li> <li>(2) Has entered the state with a job commitment or is seeking employment (whether or not currently employed).</li> </ol> <p>(b) For an individual not residing in an institution, as described in (a) of this subsection, who is incapable of stating intent, the state of residence is the state where the individual is living.</p> <p>(c) For any institutionalized individual who became incapable of indicating intent before age 21, the state of residence is:</p> <ol style="list-style-type: none"> <li>(1) That of the parent applying for Medicaid on the individual's behalf, if the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's);</li> <li>(2) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's);</li> <li>(3) The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or</li> <li>(4) The state of residence of the person or party who files an application is used if the individual has been abandoned by his or her parent(s), does not have a legal guardian and is institutionalized in that state.</li> </ol>

<sup>27</sup> 42 CFR § 435.403(h); 45 CFR §§ 155.305(a)(3)(i) and (iii).

	<p>(d) For any institutionalized individual who became incapable of indicating intent at or after age 21, the state of residence is the state in which the individual is physically present, except where another state makes a placement.</p> <p>(e) For any other institutionalized individual, the state of residence is the state where the individual is living and intends to reside. An institutionalized individual cannot be considered a Vermont resident if the individual owns a home (see § 29.08(a)(1)) in another state which the individual intends to return to, even if the likelihood of return is apparently nil.<sup>28</sup></p>
<p><b>21.07 An individual receiving Title IV-E payments<sup>29</sup> (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b></p>	
	<p>For an individual of any age who is receiving federal payments for foster care or adoption assistance under Title IV-E of the Act, the state of residence is the state where the individual lives.</p>
<p><b>21.08 An individual under age 21<sup>30</sup> (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b></p>	
	<p>For an individual under age 21 who is not eligible for Medicaid based on receipt of assistance under Title IV-E of the Act, as addressed in § 21.07, and is not receiving a state supplementary payment, as addressed in § 21.05, the state of residence is as follows:</p> <p>(a) For an individual who is capable of indicating intent and who is emancipated from his or her parent or who is married, the state of residence is determined in accordance with § 21.06(a).</p> <p>(b) For an individual not described in paragraph (a) of this subsection, not living in an institution, not eligible for Medicaid based on receipt of assistance under Title IV-E of the Act, and not receiving a state supplementary payment, the state of residence is:</p> <p>(1) The state where the individual resides, including without a fixed address; or</p> <p>(2) The state of residency of the parent or caretaker, in accordance with § 21.06(a), with whom the individual resides.</p> <p>(c) For any institutionalized individual who is neither married nor</p>

<sup>28</sup> Former Medicaid Rule 4217(F).

<sup>29</sup> 42 CFR § 403(g); 45 CFR § 155.305(a)(3)(iii).

<sup>30</sup> 42 CFR § 435.403(i); 45 CFR §§ 155.305(a)(3)(ii) and (iii). Paragraphs (a) and (b) are derived from what was formerly 42 CFR § 435.403(h). Subparagraphs (1) and (2) are new. Paragraph (c) was originally designated as 42 CFR § 435.403(h)(4).

	<p>emancipated, the state of residence is:</p> <ol style="list-style-type: none"> <li>(1) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or</li> <li>(2) The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state or residence of the guardian is used instead of the parent's).</li> </ol>
<p><b>21.09 Specific prohibitions<sup>31</sup> (<a href="#">01/15/2017</a><a href="#">07/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b></p>	
	<p>AHS will not:</p> <ol style="list-style-type: none"> <li>(a) Deny health-benefits eligibility because an individual has not resided in Vermont for a specified period.</li> <li>(b) Deny health-benefits eligibility to an individual in an institution, who satisfies the residency rules set forth in this section, on the grounds that the individual did not establish residence in Vermont before entering the institution.</li> <li>(c) Deny or terminate a Vermont resident's health-benefits eligibility because of that person's temporary absence from the state, as defined in § 21.13, if the person intends to return to Vermont when the purpose of the absence has been accomplished, unless, for purposes of Medicaid eligibility, another state has determined that the person is a resident there (see § 21.13(c)).</li> </ol>
<p><b>21.10 Interstate agreements<sup>32</sup> (<a href="#">01/15/2017</a><a href="#">07/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b></p>	
	<p>A state may have a written agreement with another state setting forth rules and procedures resolving cases of disputed residency. These agreements may establish criteria other than those specified in §§ 21.07 and 21.08, but must not include criteria that result in loss of residency in both states or that are prohibited by § 21.09. The agreements must contain a procedure for providing health benefits to individuals pending resolution of the case. States may use interstate agreements for purposes other than cases of disputed residency to facilitate administration of the program, and to facilitate the placement and adoption of a Title IV-E individual when the child and his or her adoptive parent(s) move into another state.</p>

<sup>31</sup> 42 CFR § 435.403(j).

<sup>32</sup> 42 CFR § 435.403(k); 45 CFR § 155.305(a)(3)(iii).

<b>21.11 Cases of disputed residency<sup>33</sup> (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
	If Vermont and any other state cannot resolve which state is the individual's state of residence, the state where the individual is physically located is the state of residence.
<b>21.12 Special rule for tax households with members in multiple Exchange service areas<sup>34</sup> (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
	<p>(a) Except as specified in paragraph (b) of this subsection, if all of the members of a tax household are not within the same Exchange service area, in accordance with the applicable standards in §§ 21.04 through 21.08, any member of the tax household may enroll in a QHP through any of the Exchanges for which one of the tax filers meets the residency standard.</p> <p>(b) If both spouses in a tax household enroll in a QHP through VHC, a tax dependent may only enroll in a QHP through VHC, or through the Exchange that services the area in which the dependent meets a residency standard described in §§ 21.04 through 21.08.</p>
<b>21.13 Temporary absences from the state<sup>35</sup> (<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
(a) In general	Temporary absences from Vermont do not interrupt or end Vermont residence.
(b) Definition	<p>An absence is temporary if the individual leaves the state with the intent to return when the purpose of the absence has been accomplished. Examples include, but are not limited to, absences for the purposes of:</p> <ol style="list-style-type: none"> <li>(1) Visiting;</li> <li>(2) Obtaining necessary medical care;</li> <li>(3) Obtaining education or training under a program of Vocational Rehabilitation, Work Incentive, or higher education program; or</li> <li>(4) Residence in a long-term care facility in another state, if arranged by an agent of the State of Vermont, unless the individual or their parents or legal guardian, as applicable,</li> </ol>

<sup>33</sup> 42 CFR § 435.403(m); 45 CFR § 155.305(a)(3)(iii).

<sup>34</sup> 45 CFR § 155.305(a)(3)(iv).

<sup>35</sup> 45 CFR § 155.305(a)(3)(v) (NPRM, 78 FR 4593).

	state intent to abandon Vermont residence and to reside outside Vermont upon discharge from long-term care.
(c) Exception	For purposes of Medicaid eligibility, an absence is not temporary if another state verifies that the individual meets the residency standard of such other state <sup>36</sup> .
<b>21.14 Vermont residence as Medicaid payment requirement</b> <b>(<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
	An individual must be a resident of Vermont at the time a medical service is rendered in order for Vermont Medicaid to pay for that service. The service, however, does not have to be rendered in Vermont subject to certain restrictions. <sup>37</sup>
<b>22.00 Pursuit of potential unearned income for Medicaid eligibility<sup>38</sup></b> <b>(<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
	(a) As a condition of eligibility for Medicaid, an individual is required to take all necessary steps to obtain any annuities, pensions, retirement, or disability benefits to which they may be entitled, unless they can show good cause for not doing so. Annuities, pensions, retirement, and disability benefits include, but are not limited to, veterans' compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation. Application for these benefits, when appropriate, must be verified prior to granting or continuing Medicaid.  (b) Individuals are not required to apply for Medicare part B or for cash assistance programs such as SSI/AABD or Reach Up as a condition of eligibility for Medicaid.
<b>23.00 Minimum essential coverage (<a href="#">01/15/201708/01/2016</a>, <a href="#">GCR 16-09646-02</a>)</b>	
<b>23.01 Minimum essential coverage (<a href="#">01/15/201708/01/2016</a>, <a href="#">GCR 16-09646-02</a>)</b>	
(a) In general <sup>39</sup>	Minimum essential coverage means coverage under any of the following: Government-sponsored programs, eligible employer-sponsored plans, grandfathered health plans, individual health plans and certain other health-benefits coverage.

<sup>36</sup> 42 CFR § 435.403(j)(3).

<sup>37</sup> 42 CFR § 431.52.

<sup>38</sup> Former Medicaid Rule 4137.

<sup>39</sup> 26 USC § 5000A(f); 26 CFR § 1.36B-2(c).

	<p>Individuals and their tax dependents must have minimum essential coverage (MEC) to avoid the shared responsibility payment (penalty) imposed by the Internal Revenue Service unless they qualify for an exemption from this payment. See § 23.06 for details on the eligibility determination for MEC exemptions.</p> <p>In addition, individuals who are eligible to enroll in health coverage that qualifies as MEC under this section are not eligible to receive federal tax credits and cost-sharing reductions if they enroll in a QHP. See §§ 23.01(b) through 23.01(e) for details on health coverage that qualifies as MEC for purposes of considering eligibility for the federal premium tax credit. As stated in § 23.01(c)(2), for an employer-sponsored plan to be considered as MEC when an employee or related individual applies for APTC, the plan must be affordable and meet minimum value criteria. See § 23.02 for details on affordability, and § 23.03 for details on minimum value.</p> <p>See §§ 55.02(c) and (d) for descriptions of the process for verifying eligibility for MEC when determining eligibility for APTC and CSR.</p>
(b) Government-sponsored MEC	
(1) In general <sup>40</sup>	<p>Subject to the limitation in paragraph (b)(2), an individual is eligible for government-sponsored MEC for purpose of considering eligibility for the federal premium tax credit if, as of the first day of the first full month the individual may receive benefits under the program, the individual meets the criteria for coverage under one of the following government-sponsored programs:</p> <ul style="list-style-type: none"> <li>(i) The Medicare program under part A of Title XVIII of the Act, except for an individual who must pay a premium for part A coverage and who chooses not to enroll in part A coverage (see § 23.01(e)(1));</li> <li>(ii) The Medicaid program under Title XIX of the Act, except for the following individuals: <ul style="list-style-type: none"> <li>(A) A woman who becomes pregnant while enrolled in a QHP and who, though eligible for Medicaid as a pregnant woman pursuant to § 7.03(a)(2), chooses not to enroll in Medicaid (see § 23.01(e)(5)).</li> <li>(B) An individual who becomes eligible for Medicaid coverage as medically needy only after meeting a spenddown. Such individual may apply for a hardship exemption from the personal responsibility payment as described in § 23.06(b)(7)(vii).</li> </ul> </li> </ul>

<sup>40</sup> 26 USC § 5000A(f)(1)(A); 26 CFR § 1.36B-2(c)(2)(i)

	<p>(C) An individual who is receiving coverage limited to family planning services as described in § 9.03(g).</p> <p>(D) An individual who is receiving coverage limited to the treatment of emergency services as described in § 17.02(d);</p> <p>(iii) The CHIP program under Title XXI of the Act;</p> <p>(iv) Medical coverage under chapter 55 of Title 10, United States Code, including coverage under the TRICARE program;</p> <p>(v) A health care program under chapter 17 or 18 of Title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of HHS and the Secretary of the Treasury;</p> <p>(vi) A health plan under § 2504(e) of Title 22, United States Code (relating to Peace Corps volunteers); or</p> <p>(vii) The Nonappropriated Fund Health Benefits Program of the Department of Defense, established under § 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103–337; 10 USC § 1587 note).</p>
<p>(2) Obligation to complete administrative requirements to obtain coverage<sup>41</sup></p>	<p>An individual who meets the eligibility criteria for government-sponsored MEC must complete the requirements necessary to receive benefits. An individual who fails by the last day of the third full calendar month following the event that establishes eligibility under (b)(1) of this subsection to complete the requirements to obtain government-sponsored MEC (other than a veteran's health-care program) is treated as eligible for government-sponsored MEC as of the first day of the fourth calendar month following the event that establishes eligibility.</p>
<p>(3) Special rule for coverage for veterans and other individuals under chapter 17 or 18 of Title 38, USC §<sup>42</sup></p>	<p>An individual is eligible for MEC under a health-care program under chapter 17 or 18 of Title 38, USC section only if the individual is enrolled in a health-care program under chapter 17 or 18 of Title 38, USC section identified as MEC in regulations issued under § 5000A of the Code.</p>
<p>(4) Retroactive effect of eligibility determination<sup>43</sup></p>	<p>If an individual receiving APTC is determined to be eligible for government-sponsored MEC that is effective retroactively (such as Medicaid), the individual is treated as eligible for MEC under that program no earlier than the first day of the first calendar month</p>

<sup>41</sup> 26 CFR § 1.36B-2(c)(2)(ii).

<sup>42</sup> 26 CFR § 1.36B-2(c)(2)(iii).

<sup>43</sup> 26 CFR § 1.36B-2(c)(2)(iv).

	beginning after the approval.
(5) Determination of Medicaid or CHIP ineligibility <sup>44</sup>	An individual is treated as not eligible for Medicaid or a similar program for a period of coverage under a QHP if, when the individual enrolls in the QHP, the individual is determined to be not eligible for Medicaid.
(6) Examples <sup>45</sup>	The following examples illustrate the provisions of this paragraph (b):
(i) Example 1. Delay in coverage effectiveness	On April 10, 2015, Tax filer D applies for coverage under a government-sponsored health-care program. D's application is approved on July 12, 2015, but her coverage is not effective until September 1, 2015. Under paragraph (b)(1), D is eligible for government-sponsored MEC on September 1, 2015.
(ii) Example 2. Time of eligibility	Tax filer E turns 65 on June 3, 2015, and becomes eligible for Medicare. Under § 5000A(f)(1)(A)(i), Medicare is MEC. However, E must enroll in Medicare to receive benefits. E enrolls in Medicare in September, which is the last month of E's initial enrollment period. Thus, E may receive Medicare benefits on December 1, 2015. Because E completed the requirements necessary to receive Medicare benefits by the last day of the third full calendar month after the event that establishes E's eligibility (E turning 65), under paragraph (b)(1) and (b)(2) of this subsection, E is eligible for government-sponsored MEC on December 1, 2015, the first day of the first full month that E may receive benefits under the program.
(iii) Example 3. Time of eligibility, individual fails to complete necessary requirements	The facts are the same as in Example 2, except that E fails to enroll in the Medicare coverage during E's initial enrollment period. E is treated as eligible for government-sponsored MEC under paragraph (b)(2) of this subsection as of October 1, 2015, the first day of the fourth month following the event that establishes E's eligibility (E turning 65).
(iv) Example 4. Retroactive effect of eligibility	In November 2014, Tax filer F enrolls in a QHP for 2015 and receives APTCs. F loses her part-time employment and on April 10, 2015, applies for coverage under the Medicaid program. F's application is approved on May 15, 2015, and her Medicaid coverage is effective as of April 1, 2015. Under paragraph (b)(4), F is eligible for government-sponsored MEC on June 1, 2015, the first day of the first calendar month after approval.
(v) Example 5. Determination of	In November 2014, Tax filer G applies to enroll in health coverage for 2015. AHS determines that G is not eligible for Medicaid and estimates that G's household income will be 140 percent of the FPL for G's family

<sup>44</sup> 26 CFR § 1.36B-2(c)(2)(v). The phrase in this section: "or considers (within the meaning of 45 CFR § 155.302(b))" was omitted from this paragraph, as AHS does not conduct "assessment[s] of eligibility for Medicaid and CHIP" within the meaning of 45 CFR § 155.302(b), but rather, determines eligibility for such programs.

<sup>45</sup> These examples are extracted from 26 CFR § 1.36B-2(c)(2)(vi).

Medicaid ineligibility	size for purposes of determining APTCs. G enrolls in a QHP and begins receiving APTCs. G experiences a reduction in household income during the year and his household income for 2015 is 130 percent of the FPL (within the Medicaid income threshold). However, under paragraph (b)(5), G is treated as not eligible for Medicaid for 2015.
(vi) Example 6. Mid-year Medicaid eligibility redetermination	The facts are the same as in Example 5, except that G returns to the Exchange in July 2015 and AHS determines that G is eligible for Medicaid. AHS approves G for coverage and AHS discontinues G's APTCs effective August 1. Under paragraphs (b)(4) and (b)(5), G is treated as not eligible for Medicaid for the months when G is covered by a QHP. G is eligible for government-sponsored MEC for the months after G is approved for Medicaid and can receive benefits, August through December 2015.
(c) Employer-sponsored MEC	
(1) Definition: related individual	For purposes of this subsection and §§ 23.02 through 23.04, a related individual is an individual who is not an employee of an employer offering an eligible employer-sponsored plan, but who can enroll in such plan because of their relationship to the employee. This definition has a similar meaning as the definition of "dependent" for purposes of the Small Employer Health-Benefits Program under Part Six of this rule.
(2) In general <sup>46</sup>	An employee and related individual who may enroll in an eligible employer-sponsored plan are eligible for MEC under the plan for purposes of considering eligibility for the federal premium tax credit for any month only if the plan is affordable (§ 23.02) and provides minimum value (§ 23.03). Government-sponsored programs described in paragraph (b) of this subsection are not eligible employer-sponsored plans.
(3) Plan year <sup>47</sup>	For purposes of this paragraph, a plan year is an eligible employer-sponsored plan's regular 12-month coverage period (or the remainder of a 12-month coverage period for a new employee or an individual who enrolls during a special enrollment period).
(4) Eligibility for months during a plan year	
(i) Failure to enroll in plan <sup>48</sup>	An employee or related individual may be eligible for MEC under an eligible employer-sponsored plan for a month during a plan year if the employee or related individual could have enrolled in the plan for that

<sup>46</sup> 26 CFR § 1.36B-2(c)(3)(i).

<sup>47</sup> 26 CFR § 1.36B-2(c)(3)(ii).

<sup>48</sup> 26 CFR § 1.36B-2(c)(3)(iii)(A).

	month during an open or special enrollment period.
(ii) Waiting periods <sup>49</sup>	An employee or related individual is not eligible for MEC under an eligible employer-sponsored plan during a required waiting period before the coverage becomes effective.
(iii) Example <sup>50</sup>	The following example illustrates the provisions of this paragraph (c)(4):  (A) Tax filer B is an employee of Employer X. X offers its employees a health insurance plan that has a plan year (within the meaning of paragraph (c)(3)) from October 1 through September 30. Employees may enroll during an open season from August 1 to September 15. B does not enroll in X's plan for the plan year October 1, 2014, to September 30, 2015. In November 2014, B enrolls in a QHP for calendar year 2015.  (B) B could have enrolled in X's plan during the August 1 to September 15 enrollment period. Therefore, unless X's plan is not affordable for B or does not provide minimum value, B is eligible for MEC under X's plan for the months that B is enrolled in the QHP during X's plan year (January through September 2015).
(5) Post-employment coverage <sup>51</sup>	A former employee (including a retiree), or an individual related (within the meaning of this paragraph (c)) to a former employee, who may enroll in eligible employer-sponsored coverage or in continuation coverage required under federal law or a state law that provides comparable continuation coverage is eligible for MEC under this coverage only for months that the former employee or related individual is enrolled in the coverage.
(d) Other coverage that qualifies as MEC	The following types of coverage are designated as MEC for purposes of considering eligibility for the federal premium tax credit <sup>52</sup> :  (1) <i>Self-funded student health coverage.</i> Coverage offered to students by an institution of higher education (as defined in the Higher Education Act of 1965), where the institution assumes the risk for payment of claims, are designated as MEC for plan or policy years beginning on or before December 31, 2014. For coverage beginning after December 31, 2014, sponsors of self-funded student health coverage may apply to be recognized as

<sup>49</sup> 26 CFR § 1.36B-2(c)(3)(iii)(B).

<sup>50</sup> 26 CFR § 1.36B-2(c)(3)(iii)(C).

<sup>51</sup> 26 CFR § 1.36B-2(c)(3)(iv).

<sup>52</sup> 26 USC § 5000A(f)(1)(E).

	<p>MEC.</p> <p>(2) <i>Refugee Medical Assistance supported by the Administration for Children and Families.</i> Coverage under Refugee Medical Assistance, authorized under § 412(e)(7)(A) of the INA, provides up to eight months of coverage to certain noncitizens who are considered refugees.</p> <p>(3) <i>Medicare advantage plans.</i> Coverage under the Medicare program pursuant to part C of Title XVIII of the Act, which provides Medicare parts A and B benefits through a private insurer.</p> <p>(4) <i>State high risk pool coverage.</i> State high risk pools are designated as MEC for plan or policy years beginning on or before December 31, 2014. For coverage beginning after December 31, 2014, sponsors of high risk pool coverage may apply to be recognized as MEC.</p>
<p>(e) Eligibility based on enrollment<sup>53</sup></p>	<p>An individual is eligible for MEC under the following programs for purposes of considering eligibility for the federal premium tax credit only if the individual is enrolled in the coverage:</p> <p>(1) <i>Medicare part A coverage requiring payment of premiums.</i> Coverage offered under Medicare for which the individual must pay a premium for Medicare part A coverage under § 1818 of the Act.</p> <p>(2) <i>State high risk pools.</i> Health coverage offered by a state under a qualified high risk pool as defined in § 2744(c)(2) of the PHS Act, to the extent the program is covered by a designation by HHS as MEC.</p> <p>(3) <i>Student health plans.</i> Self-funded health coverage offered by a college or university to its students, to the extent the plan is covered by a designation by HHS as MEC.</p> <p>(4) <i>TRICARE programs.</i> Coverage under the following TRICARE programs:</p> <p>(i) The Continued Health Care Benefit Program (10 USC § 1078);</p> <p>(ii) Retired Reserve (10 USC § 1076e);</p> <p>(iii) Young Adult (10 USC § 1110b); and</p> <p>(iv) Reserve Select (10 USC § 1076d).</p>

<sup>53</sup> See, IRS Notice 2013-41.

	(5) <i>MCA coverage for a pregnant woman enrolled in a QHP. Coverage offered under Medicaid for a pregnant woman pursuant to the criteria described in § 7.03(a)(2) if the woman was enrolled in a QHP when she became pregnant.</i> <sup>54</sup>
<b>23.02 Affordable coverage for employer-sponsored MEC</b> <b>(<a href="#">01/15/201708/04/2016</a>, <a href="#">GCR 16-09616-02</a>)</b>	
An individual will not be eligible for a federal premium tax credit if the employer-sponsored plan in which they may enroll is affordable. The details of affordability are described in this subsection.	
(a) In general	
(1) Affordability for employee <sup>55</sup>	Except as provided in paragraph (a)(3) of this subsection, an eligible employer-sponsored plan is affordable for an employee if the portion of the annual premium the employee must pay, whether by salary reduction or otherwise (required contribution), for self-only coverage does not exceed the required contribution percentage (as defined in paragraph (c)) of the applicable tax filer's household income for the benefit year.
(2) Affordability for related individual <sup>56</sup>	Except as provided in paragraph (a)(3) of this subsection, an eligible employer-sponsored plan is affordable for a related individual if the portion of the annual premium the employee must pay for self-only coverage does not exceed the required contribution percentage, as described in (a)(1) of this subsection.
(3) Employee safe harbor <sup>57</sup>	<p>An employee or a related individual who is eligible for a safe harbor as defined in this sub clause will not be subject to repayment of APTC based on the finding that affordable MEC was in fact available to them for all or part of a plan year, should such fact be discovered at a time subsequent to enrollment in a QHP.</p> <p>(i) An employer-sponsored plan is not affordable for an employee or a related individual for a plan year if, when the employee or a related individual enrolls in a QHP for a period coinciding with the plan year (in whole or in part), it is determined that the eligible employer-sponsored plan is not affordable for that plan year.</p> <p>(ii) This paragraph does not apply to a determination made as part of the redetermination process described in § 75.00</p>

<sup>54</sup> See, IRS Notice 2014-71.

<sup>55</sup> 26 CFR § 1.36B-2(c)(3)(v)(A)(1).

<sup>56</sup> 26 CFR § 1.36B-2(c)(3)(v)(A)(2).

<sup>57</sup> 26 CFR § 1.36B-2(c)(3)(v)(A)(3).

	<p>unless the individual receiving a redetermination notification affirmatively responds and provides current information on affordability.</p> <p>(iii) This paragraph does not apply for an individual who, with reckless disregard for the facts, provides incorrect information concerning the portion of the annual premium for coverage for the employee or related individual under the plan.</p>
(4) Wellness program incentives <sup>58</sup>	<p>Nondiscriminatory wellness program incentives offered by an eligible employer-sponsored plan that affect premiums are treated as earned in determining an employee's required contribution for purposes of affordability of an eligible employer-sponsored plan to the extent the incentives relate exclusively to tobacco use. Wellness program incentives that do not relate to tobacco use or that include a component unrelated to tobacco use are treated as not earned for this purpose. For purposes of this subsection, the term "wellness program incentive" has the same meaning as the term "reward" in 26 CFR § 54.9802-1(f)(1)(i).</p>
(5) Employer contributions to health reimbursement arrangements <sup>59</sup>	<p>Amounts newly made available for the current plan year under a health reimbursement arrangement that an employee may use to pay premiums, or may use to pay cost-sharing or benefits not covered by the primary plan in addition to premiums, reduce the employee's required contribution if the health reimbursement arrangement would be integrated, as that term is used in IRS Notice 2013-54 (2013-40 IRB 287), with an eligible employer-sponsored plan for an employee enrolled in the plan. The eligible employer-sponsored plan and the health reimbursement arrangement must be offered by the same employer. Employer contributions to a health reimbursement arrangement reduce an employee's required contribution only to the extent the amount of the annual contribution is required under the terms of the plan or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan.</p>
(6) Employer contributions to cafeteria plans <sup>60</sup>	<p>Amounts made available for the current plan year under a cafeteria plan, within the meaning of 26 USC § 125, reduce an employee's or a related individual's required contribution if:</p> <p>(i) The employee may not opt to receive the amount as a taxable benefit;</p> <p>(ii) The employee may use the amount to pay for minimum</p>

<sup>58</sup> 26 CFR § 1.36B-2(c)(3)(v)(A)(4).

<sup>59</sup> 26 CFR § 1.36B-2(c)(3)(v)(A)(5).

<sup>60</sup> 26 CFR § 1.36B-2(c)(3)(v)(A)(6).

	<p>essential coverage; and</p> <p>(iii) The employee may use the amount exclusively to pay for medical care, within the meaning of 26 USC § 213.</p>
(b) Affordability for part-year period <sup>61</sup>	Affordability under paragraph (a)(1) of this subsection is determined separately for each employment period that is less than a full calendar year or for the portions of an employer's plan year that fall in different benefit years of an applicable tax filer (a part-year period). An eligible employer-sponsored plan is affordable for a part-year period if the employee's annualized required contribution for self-only coverage under the plan for the part-year period does not exceed the required contribution percentage of the applicable tax filer's household income for the benefit year. The employee's annualized required contribution is the employee's required contribution for the part-year period times a fraction, the numerator of which is 12 and the denominator of which is the number of months in the part-year period during the applicable tax filer's benefit year. Only full calendar months are included in the computation under this paragraph.
(c) Required contribution percentage <sup>62</sup>	The required contribution percentage for 2014 is 9.5 percent. For plan years beginning in a calendar year after 2014, the percentage will be adjusted by the ratio of premium growth to income growth for the preceding calendar year and may be further adjusted to reflect changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined under IRS-published guidance. In addition, the percentage may be adjusted for plan years beginning in a calendar year after 2018 to reflect rates of premium growth relative to growth in the consumer price index.
(d) Examples <sup>63</sup>	The following examples illustrate the provisions of § 23.02. Unless stated otherwise, in each example the tax filer is single and has no tax dependents, the employer's plan is an eligible employer-sponsored plan and provides minimum value, the employee is not eligible for other MEC, and the tax filer, related individual, and employer-sponsored plan have a calendar benefit year:
(1) Example 1. Basic determination of affordability	In 2014 Tax filer C has household income of \$47,000. C is an employee of Employer X, which offers its employees a health insurance plan that requires C to contribute \$3,450 for self-only coverage for 2014 (7.3 percent of C's household income). Because C's required contribution

<sup>61</sup> 26 CFR § 1.36B-2(c)(3)(v)(B).

<sup>62</sup> 26 CFR § 1.36B-2(c)(3)(v)(C). For plan years after 2014, the required contribution percentage will be updated in accordance with IRS-published guidance, available at [www.irs.gov](http://www.irs.gov). For example, the required contribution percentage for 2016 is located at: <https://www.irs.gov/pub/irs-drop/rp-14-62.pdf>.

<sup>63</sup> 26 CFR § 1.36B-2(c)(3)(v)(D).

	for self-only coverage does not exceed 9.5 percent of household income, under paragraph (a)(1), X's plan is affordable for C, and C is eligible for MEC for all months in 2014.
(2) Example 2. Basic determination of affordability for a related individual	The facts are the same as in Example 1, except that C is married to J and X's plan requires C to contribute \$5,300 for coverage for C and J for 2014 (11.3 percent of C's household income). Because C's required contribution for self-only coverage (\$3,450) does not exceed 9.5 percent of household income, under paragraph (a)(2) of this subsection, X's plan is affordable for C and J, and C and J are eligible for minimum essential coverage for all months in 2014.
(3) Example 3. Determination of unaffordability at enrollment	<p>(i) Tax filer D is an employee of Employer X. In November 2013 AHS projects that D's 2014 household income will be \$37,000. It also verifies that D's required contribution for self-only coverage under X's health insurance plan will be \$3,700 (10 percent of household income). Consequently, AHS determines that X's plan is unaffordable. D enrolls in a QHP and not in X's plan. In December 2014, X pays D a \$2,500 bonus. Thus, D's actual 2014 household income is \$39,500 and D's required contribution for coverage under X's plan is 9.4 percent of D's household income.</p> <p>(ii) Based on D's actual 2014 household income, D's required contribution does not exceed 9.5 percent of household income and X's health plan is affordable for D. However, when D enrolled in a QHP for 2014, AHS determined that X's plan was not affordable for D for 2014. Consequently, under paragraph (a)(3), X's plan is not affordable for D and D is not eligible for MEC under X's plan for 2014.</p>
(4) Example 4. Determination of unaffordability for plan year	The facts are the same as in Example 3, except that X's employee health insurance plan year is September 1 to August 31. AHS determines in August 2014 that X's plan is unaffordable for D based on D's projected household income for 2014. D enrolls in a QHP as of September 1, 2014. Under paragraph (a)(3), X's plan is not affordable for D and D is not eligible for MEC under X's plan for the coverage months September to December 2014 and January through August 2015.
(5) Example 5. No affordability information affirmatively provided for annual redetermination.	<p>(i) The facts are the same as in Example 3, except AHS redetermines D's eligibility for APTCs for 2015. D does not affirmatively provide AHS with current information regarding affordability and AHS determines that D's coverage is not affordable for 2015 and approves APTCs based on information from the previous enrollment period. In 2015, D's required contribution for coverage under X's plan is 9.4 percent of D's household income.</p> <p>(ii) Because D does not respond to AHS's notification and AHS makes an affordability determination based on information from an earlier year, the employee safe harbor in paragraph</p>

	<p>(a)(3) does not apply. D's required contribution for 2015 does not exceed 9.5 percent of D's household income. Thus, X's plan is affordable for D for 2015 and D is eligible for MEC for all months in 2015.</p>
<p>(6) Example 6. Determination of unaffordability for part of plan year (part-year period)</p>	<p>(i) Tax filer E is an employee of Employer X beginning in May 2015. X's employee health insurance plan year is September 1 to August 31. E's required contribution for self-only coverage for May through August is \$150 per month (\$1,800 for the full plan year). AHS projects E's household income for purposes of eligibility for APTCs as \$18,000. E's actual household income for the 2015 benefit year is \$20,000.</p> <p>(ii) Under paragraph (b) of this subsection, whether coverage under X's plan is affordable for E is determined for the remainder of X's plan year (May through August). E's required contribution for a full plan year (\$1,800) exceeds 9.5 percent of E's household income (<math>1,800/18,000 = 10</math> percent). Therefore, AHS determines that X's coverage is unaffordable for May through August. Although E's actual household income for 2015 is \$20,000 (and E's required contribution of \$1,800 does not exceed 9.5 percent of E's household income), under paragraph (a)(3), X's plan is unaffordable for E for the part of the plan year May through August 2015. Consequently, E is not eligible for MEC under X's plan for the period May through August 2015.</p>
<p>(7) Example 7. Affordability determined for part of a benefit year (part-year period)</p>	<p>(i) Tax filer F is an employee of Employer X. X's employee health insurance plan year is September 1 to August 31. F's required contribution for self-only coverage for the period September 2014 through August 2015 is \$150 per month or \$1,800 for the plan year. F does not enroll in X's plan during X's open season but enrolls in a QHP for September through December 2014. F does not request APTCs and does not ask AHS to determine whether X's coverage is affordable for F. F's household income in 2014 is \$18,000.</p> <p>(ii) Because F is a calendar year tax filer and Employer X's plan is not a calendar year plan, F must determine the affordability of X's coverage for the part-year period in 2014 (September-December) under paragraph (b) of this subsection. F determines the affordability of X's plan for the September through December 2014 period by comparing the annual premiums (\$1,800) to F's 2014 household income. F's required contribution of \$1,800 is 10 percent of F's 2014 household income. Because F's required contribution exceeds 9.5 percent of F's 2014 household income, X's plan is not affordable for F for the part-year period September through December 2014 and F is not</p>

	<p>eligible for MEC under X's plan for that period.</p> <p>(iii) F enrolls in coverage for 2015 and does not ask AHS to approve APTCs or determine whether X's coverage is affordable. F's 2015 household income is \$20,000.</p> <p>(iv) F must determine if X's plan is affordable for the part-year period January 2015 through August 2015. F's annual required contribution (\$1,800) is 9 percent of F's 2015 household income. Because F's required contribution does not exceed 9.5 percent of F's 2015 household income, X's plan is affordable for F for the part-year period January through August 2015 and F is eligible for MEC for that period.</p>
<p>(8) Example 8. Coverage unaffordable at year end</p>	<p>Tax filer G is employed by Employer X. In November 2014, AHS determines that G is eligible for affordable employer-sponsored coverage for 2015. G nonetheless enrolls in a QHP for 2015 but does not receive APTC. G's 2015 household income is less than expected and G's required contribution for employer-sponsored coverage for 2015 exceeds 9.5 percent of G's actual 2015 household income. Under paragraph (a)(1) of this subsection, G is not eligible for MEC under X's plan for 2015.</p>
<p>(9) Example 9. Wellness program incentives</p>	<p>(i) Employer X offers an eligible employer-sponsored plan with a nondiscriminatory wellness program that reduces premiums by \$300 for employees who do not use tobacco products or who complete a smoking cessation course. Premiums are reduced by \$200 if an employee completes cholesterol screening within the first six months of the plan year. Employee B does not use tobacco and the cost of his premiums is \$3,700. Employee C uses tobacco and the cost of her premiums is \$4,000.</p> <p>(ii) Under paragraph (a)(4) of this subsection, only the incentives related to tobacco use are counted toward the premium amount used to determine the affordability of X's plan. C is treated as having earned the \$300 incentive for attending a smoking cessation course regardless of whether C actually attends the course. Thus, the required contribution for determining affordability for both Employee B and Employee C is \$3,700. The \$200 incentive for completing cholesterol screening is treated as not earned and does not reduce their required contribution.</p>
<p align="center"><b>23.03 Minimum value for employer-sponsored MEC<sup>64</sup> (<a href="#">01/15/201708/01/2016</a>, <a href="#">GCR 16-09616-02</a>)</b></p>	

<sup>64</sup> 45 CFR § 156.145; see, also, 26 CFR §§ 1.36B-2(c)(3)(vi) and 1.36B-6.

	An individual will not be eligible for a federal premium tax credit if the employer-sponsored plan in which they may enroll provides minimum value. An eligible employer-sponsored plan provides minimum value only if the percentage of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent, and the benefits under the plan include substantial coverage of inpatient hospital services and physician services.
<b>23.04 Enrollment in eligible employer-sponsored plan</b> <b>(<a href="#">01/15/2017</a>07/30/2014, <a href="#">GCR 16-09614-04</a>)</b>	
(a) In general <sup>65</sup>	Except as provided in paragraph (b) of this subsection, the requirements of affordability and minimum value do not apply for months that an individual is enrolled in an eligible employer-sponsored plan.
(b) Automatic enrollment <sup>66</sup>	An employee or related individual is treated as not enrolled in an eligible employer-sponsored plan for a month in a plan year or other period for which the employee or related individual is automatically enrolled if the employee or related individual terminates the coverage before the later of the first day of the second full calendar month of that plan year or other period or the last day of any permissible opt-out period provided by the employer-sponsored plan or in regulations to be issued by the Department of Labor, for that plan year or other period.
(c) Examples <sup>67</sup>	The following examples illustrate the provisions of this subsection:
(1) Example 1. Tax filer H is employed by Employer X in 2014.	H's required contribution for self-only employer coverage exceeds 9.5 percent of H's 2014 household income. H enrolls in X's calendar year plan for 2014. Under paragraph (a) of this subsection, H is eligible for MEC for 2014 because H is enrolled in an eligible employer-sponsored plan for 2014.
(2) Example 2. The facts are the same as in Example 1, except that H terminates plan coverage on June 30, 2014.	Under paragraph (a) of this subsection, H is eligible for MEC under X's plan for January through June 2014 but is not eligible for MEC under X's plan for July through December 2014.
(3) Example 3. The facts are the same as in	H terminates the coverage on January 20, 2015. Under paragraph (b) of this subsection, H is not eligible for MEC under X's plan for January

<sup>65</sup> 26 CFR § 1.36B-2(c)(3)(vii)(A).

<sup>66</sup> 26 CFR § 1.36B-2(c)(3)(vii)(B).

<sup>67</sup> 26 CFR § 1.36B-2(c)(3)(vii)(C).

Example 1, except that Employer X automatically enrolls H in the plan for calendar year 2015.	2015.
<b>23.05 Related individual not claimed as a personal exemption deduction<sup>68</sup></b> <b>(<a href="#">01/15/201707/30/2014</a>, <a href="#">GCR 16-09614-04</a>)</b>	
	An individual who may enroll in MEC because of a relationship to another person eligible for the coverage, but for whom the other eligible person does not claim a personal exemption deduction, is treated as eligible for MEC under the coverage only for months that the related individual is enrolled in the coverage.
<b>23.06 Eligibility determinations for MEC exemptions (<a href="#">01/15/201708/01/2016</a>, <a href="#">GCR 16-09616-02</a>)</b>	
(a) Definitions and general requirements <sup>69</sup>	Anything in § 23.06 to the contrary notwithstanding, AHS will adopt an exemption eligibility determination made by HHS.
(1) Definitions	As used in this § 23.06, the following terms have the following meanings:
(i) Applicant	An individual who is seeking an exemption for themselves through an application submitted to AHS.
(ii) Application filer	An applicant, an individual who is liable for the shared responsibility payment for an applicant, an authorized representative, or, if the applicant is a minor or incapacitated, someone acting responsibly for an applicant.
(iii) Exemption	An exemption from the shared responsibility payment.
(iv) Health care sharing ministry <sup>70</sup>	An organization: <ul style="list-style-type: none"> <li>(A) Which is described in § 501(c)(3) of the Code and is exempt from taxation under § 501(a) of the Code;</li> <li>(B) Members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without</li> </ul>

<sup>68</sup> 26 CFR § 1.36B-2(c)(4).

<sup>69</sup> 45 CFR §§ 155.600 and 155.625(b). Exemption applications and instructions are located at [www.healthcare.gov/health-coverage-exemptions](http://www.healthcare.gov/health-coverage-exemptions).

<sup>70</sup> 26 USC § 5000A(d)(2)(B)(ii).

		<p>regard to the state in which a member resides or is employed;</p> <p>(C) Members of which retain membership even after they develop a medical condition;</p> <p>(D) Which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999; and</p> <p>(E) Which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.</p>
(v)	Indian tribe <sup>71</sup>	Any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 USC § 1601 et seq.) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.
(vi)	Required contribution <sup>72</sup>	<p>(A) In the case of an individual eligible to purchase MEC consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage; or</p> <p>(B) In the case of an individual eligible only to purchase MEC under a health plan offered in the individual market within the state, the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the state in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).</p>
(vii)	Required contribution	The product of eight percent and the rate of premium growth over the rate of income growth for the calendar year, rounded to the nearest

<sup>71</sup> 26 USC § 45A(c)(6).

<sup>72</sup> 26 USC § 5000A(e)(1)(B).

percentage	one-hundredth of one percent.
(viii) Shared responsibility payment	The payment (penalty) imposed by the IRS with respect to a non-exempt individual who does not maintain MEC.
(ix) Tax filer	Has the same meaning as it does in § 3.00.
(2) Attestation	For purposes of this subsection, any attestation that an applicant is to provide under this subsection may be made by the application filer on behalf of the applicant.
(3) Reasonably compatible	For purposes of this subsection, AHS will consider information through electronic data sources, other information provided by the applicant, or other information in AHS's records to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not impact the eligibility of the applicant for the exemption or exemptions for which they applied.
(4) Accessibility	Information, including notices, form, and applications, must be provided to applicants in accordance with the standards specified in § 5.01(c).
(5) Notices	Any notice required to be sent by AHS to an individual in accordance with this subsection must be provided in accordance with the standards specified in § 67.00(a).
(b) Eligibility standards for exemptions <sup>73</sup>	
(1) Eligibility for an exemption	Except as specified in (7) of this paragraph (b), AHS will determine an applicant eligible for and issue a certificate of exemption for any month if AHS determines that the applicant meets the requirements for one or more of the categories of exemptions described in this paragraph for at least one day of the month.
(2) Duration of single exemption	Except as specified in (3)(ii), (6)(ii), and (7) of this paragraph (b), AHS may provide a certificate of exemption only for the calendar year in which an applicant submitted an application for such exemption.
(3) Religious conscience	(i) AHS will determine an applicant eligible for an exemption for any month if the applicant is a member of a recognized religious sect or division described in 26 USC § 1402(g)(1) and (3)(iv) of this paragraph (b), and an adherent of established tenets or teachings of such sect or division for such month.

<sup>73</sup> 45 CFR § 155.605.

	<p>(ii) <i>Duration of exemption for religious conscience.</i></p> <p>(A) AHS will grant the certificate of exemption specified in this paragraph (b)(3) to an applicant who meets the standards provided in (i) above for a month on a continuing basis, until the month after the month of the individual's 21st birthday, or until such time that an individual reports that they no longer meet those standards.</p> <p>(B) If AHS granted a certificate of exemption in this category to an applicant prior to their reaching the age of 21, AHS will send the applicant a notice upon reaching the age of 21 informing the applicant that they must submit a new exemption application to maintain the certificate of exemption.</p> <p>(iii) AHS will make an exemption in this category available prospectively or retrospectively.</p> <p>(iv) For purposes of exemption in this category, AHS must determine that:</p> <p>(A) Such sect or division thereof has the established tenets or teachings referred in (i) of this paragraph (b)(3);</p> <p>(B) That it is the practice, and has been for a period of time which AHS deems to be substantial, for members of such sect or division thereof to make provision for their dependent members which, in AHS's judgment, is reasonable in view of their general level of living; and</p> <p>(C) Such sect or division thereof has been in existence at all times since December 31, 1950.</p>
<p>(4) Membership in a health care sharing ministry</p>	<p>(i) AHS will determine an applicant eligible for an exemption for a month if for such month the applicant is a member of a health care sharing ministry as defined in § 26.03(a)(1)(iv).</p> <p>(ii) AHS will make an exemption in this category available only retrospectively.</p>
<p>(5) Incarceration</p>	<p>(i) AHS will determine an applicant eligible for an exemption for a month if the applicant is incarcerated, other than incarceration pending the disposition of charges, for such month.</p> <p>(ii) AHS will make an exemption in this category available only retrospectively.</p>

<p>(6) Membership in an Indian tribe</p>	<p>(i) AHS will determine an applicant eligible for an exemption for any month if they are a member of an Indian tribe, as defined in § 26.03(a)(1)(v), for such month.</p> <p>(ii) <i>Duration of exemption for membership in an Indian tribe.</i> AHS will grant the exemption specified in this paragraph (b)(6) to an applicant who meets the standards specified in (i) above for a month on a continuing basis, until such time that the applicant reports that they no longer meet those standards.</p> <p>(iii) AHS will make an exemption available in this category prospectively or retrospectively.</p>
<p>(7) Hardship</p>	<p>(i) <i>General.</i> AHS will grant a hardship exemption to an applicant eligible for an exemption for at least the month before, a month or months during which, and the month after, if AHS determines that:</p> <p>(A) The applicant experienced financial or domestic circumstances, including an unexpected natural or human-caused event, such that they had a significant, unexpected increase in essential expenses that prevented them from obtaining coverage under a QHP;</p> <p>(B) The expense of purchasing a QHP would have caused the applicant to experience serious deprivation of food, shelter, clothing or other necessities; or</p> <p>(C) The applicant experienced other circumstances that prevented them from obtaining coverage under a QHP, including:</p> <p>(I) They became homeless;</p> <p>(II) They were evicted in the past six months, or are facing eviction or foreclosure;</p> <p>(III) They received a shut-off notice from a utility company;</p> <p>(IV) They recently experienced domestic violence;</p> <p>(V) They recently experienced the death of a close family member;</p> <p>(VI) They recently experienced a fire, flood, or other natural or human-caused disaster that resulted in</p>

	<p>substantial damage to their property;</p> <p>(VII) They filed for bankruptcy in the last 6 months;</p> <p>(VIII) They incurred unreimbursed medical expenses in the last 24 months that resulted in substantial debt;</p> <p>(IX) They experienced unexpected increases in essential expenses due to caring for an ill, disabled, or aging family member;</p> <p>(X) They are a child who has been determined ineligible for Medicaid and CHIP, and for whom a party other than the party who expects to claim them as a tax dependent is required by court order to provide medical support. This exemption should only be provided for the months during which the medical support order is in effect; or</p> <p>(XI) As a result of an eligibility appeals decision, they are determined eligible for enrollment in a QHP, APTC or CSR for a period of time during which they were not enrolled in a QHP. This exemption should only be provided for the period of time affected by the appeals decision.</p> <p>(ii) <i>Lack of affordable coverage based on projected income.</i> AHS will determine an applicant eligible for an exemption for a month or months during which they, or another individual they attest will be included in their household, are unable to afford coverage in accordance with the standards specified in § 5000A(e)(1) of the Code (the individual's required contribution for MEC for the month (determined on an annual basis) exceeds the required contribution percentage of the individual's household income), provided that:</p> <p>(A) Eligibility for this exemption is based on projected annual household income;</p> <p>(B) An eligible employer-sponsored plan is only considered under (ii)(C) and (ii)(D) of this paragraph (b)(7) if it meets the minimum value standard described in § 23.03.</p> <p>(C) For an individual who is eligible to purchase coverage under an eligible employer-sponsored plan, AHS determines the required contribution for coverage such that:</p> <p>(I) An individual who uses tobacco is treated as not earning any premium incentive related to</p>
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	<p>participation in a wellness program designed to prevent or reduce tobacco use that is offered by an eligible employer-sponsored plan;</p> <p>(II) Wellness incentives offered by an eligible employer-sponsored plan that do not relate to tobacco use are treated as not earned;</p> <p>(III) In the case of an employee who is eligible to purchase coverage under an eligible employer-sponsored plan sponsored by the employee's employer, the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost self-only coverage.</p> <p>(IV) In the case of an individual who is eligible to purchase coverage under an eligible employer-sponsored plan as a member of the employee's household, the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost family coverage that would cover the employee and all other individuals who are included in the employee's household who have not otherwise been granted an exemption.</p> <p>(D) For an individual who is ineligible to purchase coverage under an eligible employer-sponsored plan, AHS will determine the required contribution for coverage in accordance with § 23.06(a)(1)(vi)(B), inclusive of all members of the household who have not otherwise been granted an exemption and who are not treated as eligible to purchase coverage under an eligible employer-sponsored plan, in accordance with (ii)(B) of this paragraph (b)(7); and</p> <p>(E) The applicant applies for this exemption prior to the last date on which they could enroll in a QHP for the month or months of a calendar year for which the exemption is requested.</p> <p>(F) AHS will make an exemption in this category available prospectively, and provide it for all remaining months in a coverage year, notwithstanding any change in an individual's circumstances.</p> <p>(iii) <i>Ineligible for Medicaid based on a state's decision not to expand.</i> AHS will determine an applicant eligible for an exemption for a calendar year if they have been determined ineligible for Medicaid for one or more months during the benefit year solely as a result of a</p>
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	<p>state not implementing § 2001(a) of the ACA;</p> <p>(iv) <i>Eligible for services through an Indian health care provider.</i></p> <p>(A) AHS will determine an applicant eligible for an exemption for any month if they are an Indian eligible for services through an Indian health care provider, as defined in (C) below, and not otherwise eligible for an exemption under paragraph (b)(6) or an individual eligible for services through the Indian Health Service in accordance with 25 USC §§ 1680c(a), (b), or (d)(3).</p> <p>(B) AHS will grant the exemption specified in this (7)(iv) of this paragraph (b) to an applicant who meets the standards specified in (A) above for a month on a continuing basis, until such time that the applicant reports that they no longer meet those standards.</p> <p>(C) For purposes of (A) above, <i>Indian health care provider</i> means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 USC § 1603)<sup>74</sup>.</p> <p>(D) The IRS may allow an applicant to claim the exemption specified in this (7)(iv) of this paragraph (b) without obtaining an exemption certificate from AHS.</p> <p>(v) <i>Filing threshold.</i> The IRS may allow an applicant to claim an exemption without obtaining an exemption certificate from AHS for a taxable year if, for such year, the applicant could not be claimed as a dependent by another taxpayer and the applicant's gross income was less than the applicant's applicable return filing threshold.</p> <p>(vi) <i>Self-only coverage in an eligible employer-sponsored plan.</i> The IRS may allow an applicant to claim an exemption for a calendar year if they, as well as one or more employed members of their family, has been determined eligible for affordable self-only employer-sponsored coverage through their respective employers for one or more months during the calendar year, but the aggregate cost of employer-sponsored coverage for all the employed members of the family exceeds the required contribution percentage of household income for that calendar year.</p>
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<sup>74</sup> 42 CFR § 447.50.

	(vii) <i>Enrolled in Medicaid coverage as medically needy after meeting a spenddown. AHS will determine an applicant eligible for an exemption for any month the applicant is enrolled in Medicaid coverage as medically needy after meeting a spenddown.</i>
(c) Eligibility process for exemptions <sup>75</sup>	
(1) Application	Except as specified in (2) and (3) of this paragraph (c), AHS will use an application established by HHS to collect information necessary for determining eligibility for and granting certificates of exemption as described in § 23.06(b).
(2) Alternative application	If AHS seeks to use an alternative application, such application, as approved by HHS, must request the minimum information necessary for the purposes identified in (1) of this paragraph (c).
(3) Exemptions through the eligibility process for coverage	If an individual submits the application described in § 52.02 and then requests an exemption, AHS will use information collected for purposes of the eligibility determination for enrollment in a QHP and health-benefits programs in making the exemption eligibility determination, and will not request duplicate information or conduct repeat verifications to the extent that AHS finds that such information is still applicable, where the standards for such verifications adhere to the standards specified in this subsection.
(4) Filing the exemption application	AHS will: <ul style="list-style-type: none"> <li>(i) Accept the application from an application filer; and</li> <li>(ii) Provide the tools to file an application.</li> </ul>
(5) Collection of Social Security numbers	<ul style="list-style-type: none"> <li>(i) AHS will require an applicant who has a Social Security number to provide such number.</li> <li>(ii) AHS will not require an individual who is not seeking an exemption for themselves to provide a Social Security number, except as specified in (5)(iii) of this paragraph (c).</li> <li>(iii) AHS must require an application filer to provide the Social Security number of a tax filer who is not an applicant only if an applicant attests that the tax filer has a Social Security number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size for an exemption under § 23.06(b)(7)(ii) that requires such verification.</li> </ul>

<sup>75</sup> 45 CFR § 155.610.

(6) Determination of eligibility; granting of certificates	AHS will determine an applicant's eligibility for an exemption in accordance with the standards specified in § 23.06(b), and grant a certificate of exemption to any applicant determined eligible.
(7) Timeliness standards	<p>(i) AHS will determine eligibility for exemption promptly and without undue delay.</p> <p>(ii) AHS will assess the timeliness of eligibility determinations made under this subsection based on the period from the date of application to the date AHS notifies the applicant of its decision.</p>
(8) Exemptions for previous tax years	<p>(i) Except for the exemptions described in §§ 23.06(b)(3), (6), and (7), after December 31 of a given calendar year, AHS will not accept an application for an exemption that is available retrospectively for months for such calendar year, and must provide information to individuals regarding how to claim an exemption through the tax filing process.</p> <p>(ii) AHS will only accept an application for an exemption described in § 23.06(b)(7)(i) during one of the 3 calendar years after the month or months during which the applicant attests that the hardship occurred.</p>
(9) Notification of eligibility determination for exemptions	AHS will provide timely written notice to an applicant of any eligibility determination made in accordance with this subsection. In the case of a determination that an applicant is eligible for an exemption, this notification must include the exemption certificate number for the purposes of tax administration.
(10) Retention of records for tax compliance	<p>(i) AHS will notify an individual to retain the records that demonstrate receipt of the certificate of exemption and qualification for the underlying exemption.</p> <p>(ii) In the case of any factor of eligibility that is verified through use of the special circumstances exception described in § 23.06(d)(8), the records that demonstrate qualification for the underlying exemption are the information submitted to AHS regarding the circumstances that warranted the use of the exception, as well as records of AHS's decision to allow such exception.</p>
(d) Verification process related to eligibility for exemptions <sup>76</sup>	

<sup>76</sup> 45 CFR § 155.615.

<p>(1) General rule</p>	<p>Unless a request for modification is granted under (9) of this paragraph (d), AHS will verify or obtain information as provided in this paragraph (d) in order to determine that an applicant is eligible for an exemption.</p>
<p>(2) Verification related to exemption for religious conscience</p>	<p>For any applicant who requests an exemption based on religious conscience, AHS will verify that the applicant meets the standards specified in § 23.06(b)(3) by:</p> <ul style="list-style-type: none"> <li>(i) Except as specified in (ii) below, accepting a form that reflects that the applicant is exempt from Social Security and Medicare taxes under § 1402(g)(1) of the Code;</li> <li>(ii) Except as specified in paragraphs (iii) and (iv) below, accepting their attestation of membership in a religious sect or division, and verifying that the religious sect or division to which the applicant attests membership is recognized by the SSA as an approved religious sect or division under § 1402(g)(1) of the Code.</li> <li>(iii) If information provided by an applicant regarding their membership in a religious sect or division is not reasonably compatible with other information provided by the individual or in AHS's records, AHS will follow the procedures specified in (7) of this paragraph (d).</li> <li>(iv) If an applicant attests to membership in a religious sect or division that is not recognized by the SSA as an approved religious sect or division under § 1402(g)(1) of the Code, AHS will provide the applicant with information regarding how their religious sect or division can pursue recognition under § 1402(g)(1) of the Code, and determine the applicant ineligible for this exemption until such time as AHS obtains information indicating that the religious sect or division has been approved.</li> </ul>
<p>(3) Verification related to exemption for membership in a health care sharing ministry</p>	<ul style="list-style-type: none"> <li>(i) For any applicant who requests an exemption based on membership in a health care sharing ministry, AHS will verify that the applicant meets the standards specified in § 23.06(b)(4) by, except as provided in (A) and (B) below, accepting their attestation; and verifying that the health care sharing ministry to which the applicant attests membership is known to AHS as a valid health care sharing ministry based on data provided by HHS: <ul style="list-style-type: none"> <li>(A) If information provided by an applicant regarding their membership in a health care sharing ministry is not reasonably compatible with other information provided by the individual or in AHS's records, AHS</li> </ul> </li> </ul>

	<p>will follow the procedures specified in (7) of this paragraph (d). AHS will not consider an applicant's prior or current enrollment in health coverage as not reasonably compatible with an applicant's attestation of membership in a health care sharing ministry.</p> <p>(B) If an applicant attests to membership in a health care sharing ministry that is not known to AHS as a health care sharing ministry based on information provided by HHS, AHS will provide the applicant with information regarding how an organization can pursue recognition under (ii) below, and determine the applicant ineligible for this exemption until such time as HHS notifies AHS that the health care sharing ministry meets the standards specified in § 5000A(d)(2)(B)(ii) of the Code.</p> <p>(ii) To be considered a health care sharing ministry for the purposes of this subsection, an organization must submit information to HHS that substantiates the organization's compliance with the standards specified in § 5000A(d)(2)(B)(ii) of the Code. If at any time HHS determines that an organization previously considered a health care sharing ministry for the purposes of this subsection no longer meets the standards specified in § 5000A(d)(2)(B)(ii) of the Code, HHS may revoke its earlier decision regarding the status of the health care sharing ministry.</p>
(4) Verification related to exemption for incarceration	<p>(i) For any applicant who provides information attesting that they were incarcerated for a given month in accordance with the standards specified in § 23.06(b)(5), AHS will verify their attestation through the same process as described in § 55.02(b).</p> <p>(ii) To the extent that AHS is unable to verify an applicant's attestation that they were incarcerated for a given month in accordance with the standards specified in § 23.06(b)(5) through the process described in § 55.02(b), AHS will follow the procedures specified in (7) of this paragraph (d).</p>
(5) Verification related to exemption for members of Indian tribes	<p>(i) For any applicant who provides information attesting that they are a member of an Indian tribe, AHS will use the process outlined in § 59.03 to verify that the applicant is a member of an Indian tribe.</p> <p>(ii) To the extent that AHS is unable to verify an applicant's status as a member of an Indian tribe through the process described in § 59.03, AHS will follow the procedures specified in (7) of this paragraph (d).</p>
(6) Verification related to	<p>(i) <i>In general.</i> For any applicant who requests an exemption based on hardship, AHS will verify whether the applicant has experienced the hardship to which they are attesting.</p>

<p>exemption for hardship</p>	<ul style="list-style-type: none"> <li>(ii) <i>Lack of affordable coverage based on projected income.</i> <ul style="list-style-type: none"> <li>(A) For any applicant who requests an exemption based on the hardship described in § 23.06(b)(7)(ii), AHS will verify the unavailability of affordable coverage through the procedures used to determine eligibility for APTC, including the procedures described in § 55.04(a), and the procedures used to verify eligibility for qualifying coverage in an eligible employer-sponsored plan, as specified in § 55.02(d), except as specified in (B) below.</li> <li>(B) AHS will accept an application filer's attestation for an applicant regarding eligibility for MEC other than through an eligible employer-sponsored plan, instead of following the procedures specified in § 55.02(c).</li> </ul> </li> <li>(iii) <i>Eligible for services through an Indian health care provider.</i> For any applicant who requests an exemption based on the hardship described in § 23.06(b)(7)(iv), AHS will verify whether the applicant meets the standards specified in § 23.06(b)(7)(iv) through the same process described in (5) of this paragraph (d).</li> <li>(iv) To the extent that AHS is unable to verify any of the information needed to determine an applicant's eligibility for an exemption based on hardship, AHS will follow the procedures specified in (7) of this paragraph (d).</li> </ul>
<p>(7) Inability to verify necessary information</p>	<p>Except as otherwise specified in this subsection, for an applicant for whom AHS cannot verify information required to determine eligibility for an exemption, including but not limited to when electronic data is required in accordance with this subsection but data for individuals relevant to the eligibility determination for an exemption are not included in such data sources or when electronic data is required but it is not reasonably expected that data sources will be available within the time period as specified in § 57.00(b), AHS:</p> <ul style="list-style-type: none"> <li>(i) Will make a reasonable effort to identify and address the causes of such inconsistency, including typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer;</li> <li>(ii) If unable to resolve the inconsistency through the process described in (i) above, will: <ul style="list-style-type: none"> <li>(A) Provide notice to the applicant regarding the inconsistency; and</li> <li>(B) Provide the applicant with a period of 90 days from the date on which the notice described in (A) above is sent</li> </ul> </li> </ul>

	<p>to the applicant to either present satisfactory documentary evidence via the channels available for the submission of an application (except for by telephone) or otherwise to resolve the inconsistency.</p> <p>(iii) May extend the period described in (ii)(B) above for an applicant if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period.</p> <p>(iv) During the period described in (i) and (ii)(B) above, must not grant a certificate of exemption based on the information subject to (7) of paragraph (d).</p> <p>(v) If, after the period described in paragraph (ii)(B) above, AHS remains unable to verify the attestation, AHS will determine the applicant's eligibility for an exemption based on any information available from the data sources used in accordance with this subsection, if applicable, unless such applicant qualifies for the exception provided under (8) of this paragraph (d), and notify the applicant of such determination, including notice that AHS is unable to verify the attestation.</p>
(8) Exception for special circumstances	For an applicant who does not have documentation with which to resolve the inconsistency through the process described in (7)(ii) of this paragraph (d) because such documentation does not exist or is not reasonably available and for whom AHS is unable to otherwise resolve the inconsistency, AHS may provide an exception, on a case-by-case basis, to accept an applicant's attestation as to the information which cannot otherwise be verified along with an explanation of circumstances as to why the applicant does not have documentation.
(9) Flexibility in information collection and verification	HHS may approve modification to the methods to be used by AHS for collection of information and verification as set forth in this subsection, as well as the specific information required to be collected, provided that HHS finds that such modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, and that applicable requirements under (10) of this paragraph (d), §§ 4.08 and 4.09, and § 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of such information will be met.
(10) Applicant information	AHS will not require an applicant to provide information beyond the minimum necessary to support the eligibility process for exemptions as described in this subsection.
(11) Validation of Social Security number	<p>(i) For any individual who provides their Social Security number to AHS, AHS must transmit the Social Security number and other identifying information to HHS, which will submit it to the SSA.</p> <p>(ii) To the extent that AHS is unable to validate an individual's Social Security number through the SSA, or the SSA indicates that the individual is deceased, AHS will follow</p>

	the procedures specified in (7) of this paragraph (d), except that AHS will provide the individual with a period of 90 days from the date on which the notice described in (7)(ii)(A) is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the SSA. The date on which the notice is received means 5 days after the date on the notice, unless the individual demonstrates that they did not receive the notice within the 5 day period.
(e) Eligibility redeterminations for exemptions during a calendar year <sup>77</sup>	
(1) General requirement	AHS will redetermine the eligibility of an individual with an exemption granted by AHS if it receives and verifies new information reported by such an individual, except for the exemption described in § 23.06(b)(7)(ii).
(2) Requirement for individuals to report changes	<p>(i) Except as specified in (ii) below, AHS will require an individual who has a certificate of exemption from AHS to report any change with respect to the eligibility standards for the exemption as specified in § 23.06(b), except for the exemption described in § 23.06(b)(7)(ii), within 30 days of such change.</p> <p>(ii) AHS will allow an individual with a certificate of exemption to report changes via the channels available for the submission of an application, as described in § 23.06(c)(4).</p>
(3) Verification of reported changes	<p>AHS will:</p> <p>(i) Verify any information reported by an individual with a certificate of exemption in accordance with the processes specified in § 23.06(d) prior to using such information in an eligibility redetermination.</p> <p>(ii) Notify an individual in accordance with § 23.06(c)(9) after redetermining their eligibility based on a reported change.</p> <p>(iii) Provide periodic electronic notifications regarding the requirements for reporting changes and an individual's opportunity to report any changes, to an individual who has a certificate of exemption for which changes must be reported in accordance with (2) of this paragraph (e) and who has elected to receive electronic notifications, unless they have declined to receive such notifications.</p>
(4) Effective date of changes	AHS will implement a change resulting from a redetermination under this paragraph for the month or months after the month in which the redetermination occurs, such that a certificate that was provided for the

<sup>77</sup> 45 CFR § 155.620.

	month in which the redetermination occurs, and for prior months remains effective.
(f) [Reserved]	
(g) Reporting <sup>78</sup> (requirement to provide information related to tax administration)	<p>If AHS grants an individual a certificate of exemption in accordance with § 23.06(c)(9), AHS will transmit to the IRS at such time and in such manner as the IRS may specify:</p> <ul style="list-style-type: none"> <li>(1) The individual's name, Social Security number, and exemption certificate number;</li> <li>(2) Any other information required in guidance published by the Secretary of the Treasury in accordance with 26 CFR § 601.601(d)(2).</li> </ul>
(h) Right to appeal <sup>79</sup>	<ul style="list-style-type: none"> <li>(1) For an eligibility determination made by HHS, the individual will appeal the determination with the HHS appeals entity if the appeal is limited to a determination of eligibility for an exemption.<sup>80</sup></li> <li>(2) For an eligibility determination made by AHS, AHS will include the notice of the right to appeal and instructions regarding how to file an appeal in any notification issued in accordance with § 23.06(c)(9).</li> </ul>

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<sup>78</sup> 45 CFR § 155.630.

<sup>79</sup> 45 CFR § 155.635.

<sup>80</sup> 45 CFR § 155.505(c)(2).