

**SHO# 14-002**

November 7, 2014

**Re: Minimum Essential Coverage**

Dear State Health Official:  
Dear State Medicaid Director:

In this letter, we provide guidance on the considerations that the Secretary of Health and Human Services (HHS) intends to apply in exercising her authority under section 5000A(f)(1)(E) of the Internal Revenue Code of 1986 (“the Code”) to recognize certain types of Medicaid coverage as minimum essential coverage (MEC). This includes certain coverage for low-income pregnant women, coverage for medically needy individuals and coverage under a demonstration program authorized under section 1115 of the Social Security Act (“the Act”), which are not included as MEC under regulations implementing section 5000A(f)(1)(ii) of the Code. In addition, we are announcing the determination by the HHS Secretary under this authority that certain coverage for low-income pregnant women is MEC. This letter also clarifies how other Medicaid and CHIP coverage is regarded as MEC, and discusses related federal guidance issued today by the Internal Revenue Service (IRS) to ensure pregnant women are not adversely impacted by a decision either to recognize or to not recognize certain coverage as MEC. Finally, this letter discusses hardship exemptions and the availability of special enrollment periods for individuals enrolled in Medicaid coverage that is not MEC.

### **Background**

Under section 36B(c)(2)(B) of the Code, as implemented in regulations at 26 CFR 1.36B-2(a)(2), individuals generally are not eligible to receive a premium tax credit to support enrollment in a Qualified Health Plan (QHP) through the Marketplace for any month for which the individual is considered eligible for MEC. The term “minimum essential coverage” is defined in section 5000A(f) of the Code. Section 5000A(f)(1)(A) of the Code provides that coverage provided under the “Medicaid program under title XIX of the Social Security Act (Act)” and coverage provided under the “CHIP program under title XXI of the Act” is MEC. Thus, individuals eligible for Medicaid or CHIP generally are not eligible for advanced payment of the premium tax credit (APTC) or for cost sharing reductions (CSR) associated with enrollment in a QHP.

Under section 5000A of the Code, “nonexempt individuals” must be enrolled in MEC for each month beginning after December 31, 2013, or make an additional payment (“shared responsibility payment”) with their federal income tax return for the taxable year that includes

such month.<sup>1</sup> In general, individuals enrolled in Medicaid or CHIP will have satisfied the requirement to be enrolled in MEC.

On August 30, 2013, the IRS issued final regulations ([“August 2013 IRS final rule”](#)) on the requirement to maintain MEC. This IRS rule generally provides that Medicaid and CHIP coverage is MEC under section 5000A(f)(1) of the Code, but provides that the following types of coverage provided under a Medicaid state plan are not considered MEC within the meaning of the Code at section 5000A(f)(1)(A)(ii):<sup>2</sup>

1. Coverage of family planning services for individuals eligible for coverage under section 1902(a)(10)(A)(ii)(XXI) of the Act;
2. Coverage of tuberculosis-related services for individuals eligible for coverage under section 1902(a)(10)(A)(ii)(XII) of the Act;
3. Coverage of pregnancy-related services for pregnant women eligible under section 1902(a)(10)(A)(i)(IV) or 1902(a)(10)(A)(ii)(IX) of the Act; and
4. Coverage provided to otherwise eligible non-qualified non-citizens, which is limited to treatment of emergency medical conditions in accordance with 8 U.S.C. 1611(b)(1)(A), as authorized by section 1903(v) of the Act.

On January 27, 2014, the IRS published a notice of proposed rulemaking, ([“January 2014 IRS proposed rule”](#))<sup>3</sup> which would address whether Medicaid coverage for medically needy individuals and coverage authorized under certain section 1115 demonstration projects would be recognized as MEC. Specifically, the January 2014 IRS proposed rule would specify that the following types of Medicaid coverage would not be included as government-sponsored MEC:<sup>4</sup>

- Coverage for individuals eligible as medically needy under section 1902(a)(10)(C) of the Social Security Act and 42 CFR 435.300 et seq.; and
- Coverage authorized under section 1115(a)(2) of the Act as part of a demonstration project.

Under section 5000A(f)(1)(E) of the Code, the HHS Secretary, in coordination with the Treasury Secretary, has authority to determine that coverage which is not otherwise recognized as MEC under the section 5000A(f)(1)(A)-(D) of the Code will be recognized as MEC. The exclusion under the IRS regulations of certain Medicaid and CHIP coverage from the scope of government-sponsored MEC under section 5000A(f)(1)(A) of the Code does not affect this separate statutory authority.

The decision regarding whether or not to recognize coverage as MEC has significant implications for consumers. As noted above, individuals eligible for Medicaid coverage that is

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<sup>1</sup> This requirement is implemented at 26 CFR 1.5000A-1.

<sup>2</sup> See 26 CFR 1.5000A-2(b)(1)(ii).

<sup>3</sup> See *Minimum Essential Coverage and Other Rules Regarding the Shared Responsibility Payment for Individuals*, 79 FR 4302 (January 27, 2014).

<sup>4</sup> See § 1.5000A-2(b)(2)(v) and (vi) of the January 2014 proposed rule.

considered MEC are ineligible for APTC and CSR. Individuals eligible for Medicaid coverage that is not considered MEC could obtain APTC and CSR when enrolled in a QHP through the Marketplace, or they may elect to enroll in Medicaid and to receive APTC and CSR for enrollment in a QHP. Consumers eligible for assistance through both programs may also elect to enroll only in Medicaid; however, unless they are eligible for a hardship or other exemption from the requirement to maintain minimum essential coverage, individuals who elect only to enroll in Medicaid coverage that is not recognized as MEC may be subject to the shared responsibility payment.

In coordination with the Treasury Secretary, we set forth in this letter:

1. Notice of the determination by the HHS Secretary under her authority under section 5000A(f)(1)(E) of the Code that coverage for low-income pregnant women in states that have elected in their Medicaid state plan to provide the same coverage to low-income pregnant women as that provided to other categorically needy individuals eligible under the state plan is MEC;
2. Guidance on the considerations that the HHS Secretary intends to apply, in exercising her authority under section 5000A(f)(1)(E) of the Code, in determining whether to recognize as MEC Medicaid coverage for low-income pregnant women in other states, coverage provided for medically needy individuals, and coverage provided pursuant to a section 1115 demonstration project;
3. The process that the HHS Secretary will use to designate Medicaid coverage as MEC under her authority; and
4. Protections for consumers enrolled only in Medicaid coverage that is not recognized as MEC.

This letter does not address coverage under a Medicaid state plan that is limited to family planning services, tuberculosis-related services or treatment of emergency medical conditions. IRS regulations except such coverage from MEC and this exception is not impacted by this guidance.

### **Coverage Provided to Low-income Pregnant Women**

Pregnant women eligible for Medicaid under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act are referred to as “low-income pregnant women.” As noted, the coverage provided to low-income pregnant women under Medicaid is not recognized as MEC under the August 2013 IRS final rule. In contrast, Medicaid coverage for “qualified pregnant women” eligible under section 1902(a)(10)(A)(i)(III) of the Act, coverage for pregnant women eligible under section 1931 of the Act, and coverage for pregnant women under CHIP provided in accordance with section 2112 of the Act, is recognized as MEC under the IRS regulation.

The treatment of coverage for low-income pregnant women under the IRS regulation is based on clause (VII) in the matter following section 1902(a)(10)(G) of the Act, which limits Medicaid coverage for low-income pregnant women to services that are “related to pregnancy ... and to other conditions that may complicate pregnancy” (hereinafter referred to as “pregnancy-related services”). However, regulations published in March 2012 make clear that per 42 CFR 435.116(d), states have the option to provide low-income pregnant women with all Medicaid services that are covered under the state plan for other categorically needy beneficiaries (referred to hereinafter as “full Medicaid benefits”).

To implement changes in federal rules related to Medicaid eligibility under the Affordable Care Act, all states were required to submit a new state plan amendment (SPA) for coverage of pregnant women under MAGI. In the SPA, states must indicate whether they cover full Medicaid benefits for all pregnant women or whether they are establishing an income level above which pregnant women receive pregnancy-related services. States establishing such an income level must describe any difference in the coverage afforded to low-income pregnant women above the specified level, which must be approved by the Secretary. All states have submitted the required SPA, and the vast majority has elected the option to provide full Medicaid benefits to all pregnant women.<sup>5</sup>

The HHS Secretary, in coordination with the Treasury Secretary, has determined that, notwithstanding the treatment of Medicaid coverage for low-income pregnant women under the IRS regulation, coverage for low-income pregnant women eligible under section 1902(a)(10)(A)(i)(IV) or 1902(a)(10)(A)(ii)(IX) of the Act is recognized as MEC if the coverage afforded under the state plan to such pregnant women consists of full Medicaid benefits. Accordingly, in states that elect to provide full Medicaid coverage for all pregnant women in their SPA, that coverage is recognized as MEC pursuant to the determination made by the Secretary announced in this letter.

For states that are approved to establish an income level above which low-income pregnant women receive “pregnancy-related services,” HHS intends to review the benefits covered, and any procedural or other policy limitations on coverage of such benefits, relative to the coverage provided to other categorically needy pregnant beneficiaries, to determine whether or not the coverage provided is equivalent to full Medicaid benefits. Coverage which is determined equivalent to the full Medicaid benefits provided to other categorically needy pregnant beneficiaries will be recognized as MEC. States will be notified in the approval letter for their SPA of our determination. For states whose SPA for coverage of pregnant women already has been approved, a separate letter will be issued. This information also will be posted on the [www.Medicaid.gov](http://www.Medicaid.gov) website in a manner accessible to the public. We expect that states will also

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<sup>5</sup> States have the option under 42 CFR 435.116(d) to provide full Medicaid benefits to all pregnant women eligible for Medicaid or to establish an income limit at or below which pregnant women are entitled for full Medicaid benefits, and above which pregnant women are limited to pregnancy-related services. The regulation at 42 CFR 435.116 relating to eligibility for pregnant women does not distinguish between “qualified pregnant women,” “low-income pregnant women,” and pregnant women eligible under section 1931 of the Act *per se*. However, if a state elects to limit services for pregnant women above the applicable income limit, those with income above that limit correlate to “low-income pregnant women” eligible under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX), while those with income at or below that limit correlate to “qualified pregnant women” eligible under section 1902(a)(10)(A)(i)(III) of the Act and pregnant women eligible under section 1931 of the Act.

inform pregnant women enrolled in Medicaid if their coverage is not considered MEC. As described further below, a women enrolled in coverage that is not MEC because it is limited to pregnancy-related services can qualify for a hardship exemption.

#### Additional guidance from IRS for women enrolled in a QHP when they become pregnant

As noted above, under section 36B(c)(2)(B) of the Code, individuals who are eligible for MEC are not eligible for APTC for enrollment in a QHP. Because of higher income eligibility standards applicable in many states for pregnant women under Medicaid or CHIP, it will not be uncommon for women to be eligible for Medicaid only for the duration of their pregnancy, but to otherwise be eligible for APTC and CSR for enrolling in a QHP. To require women enrolled in coverage in a QHP who become pregnant to enroll instead in Medicaid or CHIP (or to forego the premium tax credit) for the duration of their pregnancy could undermine the ability of such women to maintain continuity of coverage and providers.

To avoid requiring such disruption, IRS is releasing concurrent guidance (Notice 2014-71) under which women who are enrolled in a QHP and who become eligible for Medicaid or CHIP that is recognized as MEC as a result of pregnancy (either under IRS regulations implementing section 5000A(f)(1)(A) of the Code or in accordance with this State Health Official letter) will be considered eligible for MEC for purposes of premium tax credit eligibility only if they elect to enroll in the Medicaid or CHIP coverage for which they are eligible on the basis of pregnancy. This approach enables pregnant women who are enrolled in a QHP prior to becoming pregnant and eligible for Medicaid or CHIP on that basis to choose to enroll in coverage under Medicaid or CHIP, or to remain enrolled in their QHP with continued receipt of APTC and CSR, but not to choose both.

#### Coverage of children in CHIP

States have the option to cover unborn children as targeted low-income children under the CHIP regulations. States exercise this option by electing to define a child as including the period from conception to birth per the definition of “child” in 42 CFR 457.10. If a pregnant woman is eligible for Medicaid the child she is expecting may not receive coverage under CHIP, just as a child who is eligible for Medicaid is not eligible for coverage under CHIP. States that take up this option may preclude eligibility for unborn children under CHIP if the pregnant woman is herself enrolled in other creditable coverage, similar to the restriction on eligibility under CHIP for children enrolled in other creditable coverage under section 2110(b)(1)(C) of the Act and 42 CFR 457.310(B)(2)(ii).

Coverage under CHIP is recognized as MEC under the IRS regulation. However, inasmuch as CHIP coverage under the unborn child option is coverage for the unborn child, such coverage does not result in the pregnant woman’s ineligibility for an APTC for enrollment in a QHP, provided that she meets all other eligibility criteria. This effectively gives pregnant women who are eligible for APTC for enrollment in a QHP a choice of CHIP coverage for the child she is expecting or APTC for QHP coverage for herself. If the state does not limit CHIP eligibility for unborn children based on the enrollment of the pregnant woman in other creditable coverage, she may elect both sources of coverage. As described below, a pregnant women electing only CHIP coverage under the unborn child option can qualify for a hardship exemption.

### **Coverage Provided to Medically Needy Individuals**

Under section 1902(a)(10)(C) of the Act, states have the option to provide “medically needy” coverage to certain individuals who are not eligible for coverage under a categorically needy eligibility group under section 1902(a)(10)(A) of the Act, because their income exceeds the applicable eligibility standard.<sup>6</sup> States are not required to provide coverage to medically needy individuals, but if they do, they must cover medically needy pregnant women and individuals under the age of 18. States also may cover as medically needy aged, blind and disabled individuals, individuals under age 19, 20 or 21, and parents and caretaker relatives. States do not have the option to cover other adults between the ages of 21 and 64 as medically needy.

States that elect to provide coverage to medically needy individuals must establish a “medically needy income level” (MNIL). Individuals with income above the MNIL can establish eligibility for medically needy coverage by incurring medical expenses to “spend down” to the MNIL. States elect a “budget period” of between one and six months. At the beginning of the budget period, an individual with income above the MNIL will not be eligible. As soon as the individual has incurred sufficient medical expenses, such that, after subtracting incurred medical expenses, her income falls below the MNIL, she is eligible for coverage for the rest of the budget period. Alternatively, under section 1902(f)(2) of the Act, states can allow individuals, at their option, to spend down to the MNIL through making a lump sum or installment payments directly to the Medicaid agency each budget period, thereby ensuring no break in coverage. Individuals whose income is at or below the MNIL without first incurring medical expenses are not required to meet a “spend down” amount; they are said to be “eligible without spend down.” States also can apply an asset test for medically needy coverage.

Coverage provided to medically needy individuals is not required to be as comprehensive as that provided to categorically eligible individuals. For this reason, the IRS proposed regulation at 26 CFR 1.5000A-2(b)(2)(v) provides that coverage for medically needy individuals is not MEC. However, many states afford medically needy individuals full Medicaid benefits. In such situations, recognition of medically needy coverage as MEC under section 5000A(f)(1)(E) of the Code may be appropriate.

In anticipation of IRS final rulemaking, in coordination with the Treasury Secretary, we have determined that, if Medicaid coverage provided to medically needy individuals is not recognized as MEC under forthcoming IRS final regulations, we will consider recognizing as MEC coverage provided to medically needy individuals by applying the two-prong review strategy described below.<sup>7</sup> To the extent we conclude that medically needy coverage in a particular state will be recognized as MEC, we provide a letter announcing such designation to the state and make it available on the Medicaid.gov website. We will also make a chart available that reflects the Secretary’s designation for each state which provides coverage to medically needy individuals.

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<sup>6</sup> Coverage of medically needy individuals is implemented in the regulations at 42 CFR Part 435 Subpart D.

<sup>7</sup> The guidance provided in this letter with respect to medically needy coverage assumes that the treatment of such coverage in the IRS regulations will be finalized as proposed and will be effective upon publication of the IRS final rule. If the treatment of medically needy coverage under the IRS regulation is not finalized as proposed, we will provide different guidance, as appropriate.

Under the two-pronged review, we first will determine whether the coverage afforded to medically needy individuals is comprehensive. We will consider coverage for medically needy individuals to be comprehensive if it consists of full Medicaid benefits which are not substantially less in amount, duration or scope than the benefits covered under the Medicaid state plan for categorically needy individuals eligible under a mandatory eligibility group described in section 1902(a)(10)(A)(i) of the Act (e.g., the benefits covered for parents and other caretaker relatives eligible under 42 CFR 435.110 and for aged, blind and disabled individuals eligible under 42 CFR 435.120 or 435.121)<sup>8</sup>. Coverage furnished through an alternative benefit plan in accordance with section 1937 of the Act will not be considered in determining whether the coverage afforded to medically needy individuals is comprehensive. We will not take into consideration whether the state covers nursing facility services, or other services that are not generally covered by QHPs, in determining whether coverage for medically needy individuals is MEC.

If the coverage afforded to medically needy individuals in the state is comprehensive as described above, the second prong of our review will relate to whether the individual is required to meet a spend-down amount in order to establish medically needy eligibility. Medically needy coverage provided to individuals who are eligible with no spend-down requirement will satisfy the second prong of the test and will be recognized as MEC. Comprehensive medically needy coverage provided to individuals who must meet a spend-down requirement will not satisfy the second prong of the test and will not be recognized as MEC. As described below, an individual enrolled in coverage for medically needy individuals that is not MEC can qualify for a hardship exemption.

#### Eligibility in 209(b) States with Spend-Down

Aged, blind and disabled individuals who have income over the income standard for coverage under the mandatory categorically needy eligibility group for aged, blind and disabled individuals in a “209(b) state” can establish eligibility through a spend down process similar to that available to individuals seeking coverage under a state’s optional medically needy eligibility group. Mandatory coverage for aged, blind and disabled individuals in 209(b) states is codified at 42 CFR 435.121. Neither the August 2013 IRS final rule nor the January 2014 IRS proposed rule provide for an exception from consideration as government-sponsored MEC Medicaid coverage that is provided to individuals eligible under 42 CFR 435.121 (whether or not a spend down must be met to establish such eligibility). Therefore, Medicaid for aged, blind and disabled individuals eligible for mandatory coverage under 42 CFR 435.121 with or without having to meet a spend down is considered government-sponsored MEC under section 5000A(f)(1)(A)(ii) and the implementing IRS regulations. As clarified in IRS Notice 2013-41, such coverage is treated as MEC under section 36B(c)(2)(B) of the Code for purposes of eligibility for the premium tax credit only once the Medicaid agency has approved eligibility for such coverage. Unless and until the Medicaid agency determines an individual eligible for coverage under the 209(b) category, the individual, if otherwise eligible, may enroll in a QHP and receive APTC and CSR.

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<sup>8</sup> If a state offers medically needy beneficiaries an option of ABP coverage in addition to comprehensive state plan coverage, the ABP option will not affect the designation of the medically needy coverage as MEC.

## **Coverage provided under Section 1115 Demonstrations**

Section 1115 of the Act provides the Secretary with discretion to approve state Medicaid demonstration projects that she determines are designed to further the objectives of the Medicaid statute. Under section 1115(a)(1) of the Act, the Secretary is authorized to waive compliance with requirements contained in section 1902 of the Act to the extent necessary to enable states to carry out such demonstration projects. Under section 1115(a)(2) of the Act, the Secretary may authorize Federal financial participation (FFP) for expenditures which otherwise would not be permitted under the statute. The Medicaid demonstrations adopted by a number of states to provide only family planning benefits to individuals not eligible under the state plan provide one example of such demonstration projects. Section 1115 authority also may be used to approve CHIP demonstration projects.

The January 2014 IRS proposed rule would exclude coverage provided under a demonstration project authorized under section 1115(a)(2) of the Act from the IRS's interpretation of what constitutes MEC under section 5000A(f)(1)(A)(ii) of the Code.<sup>9</sup> Because many demonstration projects involve authority under both section 1115(a)(1) and section 1115(a)(2), this guidance does not distinguish between demonstration projects authorized under section 1115(a)(1) versus section 1115(a)(2).

Below we provide guidance on the considerations the HHS Secretary, in consultation with the Treasury Secretary, intends to apply in determining whether to recognize coverage authorized under a section 1115 demonstration project as MEC if IRS regulations which except such coverage from MEC under section 5000A(f)(1)(ii) of the Code are published in final rulemaking.

### *1. Considerations for Recognition of Section 1115 Demonstration Coverage as Minimum Essential Coverage*

In reviewing whether coverage provided under a Medicaid or CHIP demonstration project will be recognized as MEC, we intend to consider whether such coverage, taking into account the amount, duration and scope of covered benefits as well as any cost sharing or other out-of-pocket liability incurred by the beneficiary, consists of either –

- (1) Coverage that meets the requirements set forth in 42 CFR Part 440 Subpart C for an Alternative Benefit Plan or, in the case of a CHIP demonstration project, that meets the requirements for benchmark or benchmark-equivalent coverage set forth in section 2013 of the Act and 42 CFR 457 Subpart D; or
- (2) Coverage of all benefits and services that is not less in amount, duration or scope than the coverage provided to categorically needy individuals eligible under a mandatory

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<sup>9</sup> As discussed below, this would not include coverage funded through section 1115(a)(2) demonstration expenditure authority allowing for the federal match of a designated state health program (DSHP). While federal matching funds are provided, coverage under a DSHP is coverage under a state program, not Medicaid. Coverage under state programs is not included in the definition of MEC in section 5000A(f)(1) of the Code and was not addressed in the IRS rulemaking. The guidance provided in this letter will be effective upon publication of the IRS final rule, at which point we will affirm the applicability of the guidance in this letter. If the policy reflected in the IRS final regulation is different than the policy reflected in the January 2014 IRS proposed rule, we will provide different guidance, as appropriate.

eligibility group under the state plan described in section 1902(a)(10)(A)(i) of the Act (other than section 1902(a)(10)(i)(IV) or (VIII)) (e.g., that provided to individuals eligible under Section 435.110, 435.118, 435.120 and 435.121) who are not affected by the terms of the demonstration project, or which is substantially equivalent to such coverage.<sup>10</sup> We will not take into consideration nursing facility services, or other services that are not generally covered by QHPs, in determining whether coverage provided under a Medicaid or CHIP demonstration project is MEC.

Most demonstration projects either clearly provide such coverage, or do not. Demonstration projects that provide the same coverage as that afforded to mandatory categorically needy individuals eligible under the state plan whose benefits are not limited under the demonstration project – including under an Alternative Benefit Plan, benchmark or benchmark-equivalent coverage – will be recognized as MEC. Conversely, coverage that is limited to a specific category of benefits – such as family planning services, prescription drugs, services to treat a specific medical condition – or to services available from a limited, local network of providers which does not meet the standard, will not be recognized as MEC.

A subset of the demonstration projects offer a benefit package that neither clearly meets nor clearly falls short of the standard for recognition as MEC. CMS will work with each state operating such a demonstration to evaluate the benefits, and determine whether it meets the standard for recognition as MEC.<sup>11</sup>

In some states, the Secretary has authorized expenditures under section 1115 to provide federal support for state health programs (referred to as a “designated state health program” or “DSHP”). FFP authorized under section 1115 of the Act for a DSHP does not impact the MEC status of such state health programs, which will not be recognized as MEC unless the state has obtained such designation from the Secretary in accordance with the regulations at 45 CFR 156.604.

Recognition of existing section 1115 coverage as MEC by the HHS Secretary will be announced in a letter from CMS and posted on [www.Medicaid.gov](http://www.Medicaid.gov). As new section 1115 demonstration projects are approved, or as section 1115 demonstration projects are amended, CMS will evaluate the benefits provided against the standard for designation as MEC and will include this information in the demonstration Special Terms and Conditions. CMS will also post on its website a chart that includes a list of each state’s coverage authorized under section 1115 and whether that coverage is recognized by the Secretary as MEC.

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<sup>10</sup> Benefits provided to low-income pregnant women under section 1902(a)(10)(A)(i)(IV) of the Act are excluded as a basis for comparison in the standard set forth above because, as discussed above, such coverage may be limited under the Medicaid statute and, conversely, states also may elect to provide additional benefits for pregnant women not covered for other categorically needy beneficiaries per clause (V) in the matter following section 1902(a)(10)(G) of the Act and 42 CFR Section 440.240(p).

<sup>11</sup> In the event that coverage under a demonstration project were authorized for individuals required to meet a spend-down, we also would consider this factor in determining whether the coverage provided under the demonstration would be recognized as MEC in the same manner as the requirement to meet a spend-down will be considered in determining whether coverage for medically needy individuals will be recognized as MEC under the guidance provided in this letter.

2. *Demonstration authority unrelated to scope of benefits*

The Secretary has authorized a range of demonstration projects under section 1115 of the Act which do not restrict benefits provided to individuals enrolled under the state plan; for example, demonstration projects which permit a system of managed care or other service delivery arrangements that would not otherwise be permissible under title XIX; and demonstration projects authorizing policies and procedures to simplify the eligibility and enrollment process for consumers, ease administrative burden for states and reduce churn, such as permitting the state to use administrative transfers with no income determination for people considered extremely likely to be eligible based on other data under title XIX. Such demonstrations do not limit the scope of coverage under section 1115 authority; thus, inasmuch as coverage under the state plan remains the same, such demonstrations would be recognized as MEC.

**Implications for beneficiaries enrolled in Medicaid coverage not recognized as MEC**

1. *Hardship exemptions and the shared responsibility payment*

As noted above, under section 5000A of the Code, individuals who are not enrolled in MEC generally are subject to a shared responsibility payment unless eligible for an exemption from the requirement to maintain minimum essential coverage. Thus, individuals enrolled in Medicaid coverage that is not recognized as MEC (“non-MEC Medicaid”) may be subject to the shared responsibility payment, unless they also are enrolled in a QHP or other coverage that is recognized as MEC or are eligible for an exemption.

Because individuals enrolled in non-MEC Medicaid may not have known at the time of open enrollment for 2014 that their Medicaid coverage is not MEC, on January 27, 2014, the IRS determined that the shared responsibility payment is not imposed with respect to an individual for months in 2014 when the individual is enrolled in Medicaid coverage that is not considered MEC under the August 2013 IRS final rule or the January 2014 IRS proposed rule. See Notice 2014-10, Section 5000A Transition Relief for Individuals with Certain Government-Sponsored Limited-Benefit Health Coverage.

Thus, to the extent to which coverage provided to pregnant women, medically needy individuals or individuals eligible under a demonstration program authorized under section 1115 of the Act is not recognized as MEC under IRS regulations and is not recognized as MEC in accordance with this guidance, individuals enrolled for such coverage in 2014 are exempt from the shared responsibility payment for the months of such enrollment. Individuals enrolled in Medicaid for coverage only of family planning services or for tuberculosis-related services under the state plan, as well as otherwise-eligible non-qualified citizens whose coverage is limited to treatment of emergency medical conditions, similarly are exempt from the shared responsibility payment in 2014 for the months of such enrollment, per IRS Notice 2014-10.

Exemptions from the requirement to maintain MEC are set forth in section 5000A(e) of the Code. Under section 5000A(e)(5), the HHS Secretary, in coordination with the Secretary of Treasury, has discretion to provide a hardship exemption in appropriate circumstances. On June 26, 2013, the CMS Center for Consumer Information and Insurance Oversight (CCIIO) issued [\*Guidance on Hardship Exemption Criteria and Special Enrollment Periods\*](#), to explain additional criteria that may be considered by a Marketplace in considering a request for a hardship exemption under 45 CFR 155.605(g)(1) of the regulations. To avoid any hardship that would

result for pregnant women and medically needy individuals who may choose to enroll in Medicaid coverage that is not recognized as MEC under either the IRS regulations or the Secretary in accordance with this letter, a hardship exemption will also be available under forthcoming guidance to the following individuals effective January 1, 2015:

- Pregnant women whose coverage is limited to pregnancy-related services not recognized as MEC under the August 2013 IRS final rule or this letter;
- Pregnant women receiving coverage through enrollment of their unborn child in CHIP; and
- Individuals receiving medically needy coverage that is not recognized as MEC under IRS regulations or this letter.

CMS will issue additional guidance providing further details on the hardship exemption for these individuals.

Individuals living in a “non-expansion state” (i.e., a state that has not implemented the Medicaid coverage expansion to cover non-pregnant, non-disabled adults under section 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119) who have income at or above 100 percent of the FPL may be eligible for APTC and CSR when they enroll in a QHP. Such individuals who elect to enroll only in section 1115 demonstration coverage that is not MEC will not be eligible for a hardship exemption under the CCIIO guidance described above. However, these individuals may qualify for an existing hardship exemption available to individuals living in a non-expansion state who have MAGI-based income at or below 133 percent of the FPL and are not eligible for Medicaid solely because the state has not expanded coverage to the adult group described in 42 CFR 435.119. The existing hardship exemption under 45 CFR 155.605(g)(4) applies whether or not they elect to enroll in section 1115 demonstration coverage that is not recognized as MEC.

*2. Enrollment in a qualified health plan for individuals terminated from non-MEC Medicaid*

Under 45 CFR 155.410(e), enrollment in a qualified health plan generally is limited to the open enrollment period. For 2015, open enrollment will extend from November 15, 2014 through February 15, 2015. To enroll in a QHP outside of the open enrollment period, an individual must qualify for a special enrollment period (SEP). Per 45 CFR 155.420(c), a SEP typically extends for 60 days from the date of the qualifying event which triggered the SEP.

Under Exchange regulations at 45 CFR 155.420(d)(1), loss of eligibility for MEC qualifies an individual for a SEP. On May 27, 2014, CMS published a final regulation providing that loss of coverage for low-income pregnant women under section 1902(a)(10)(A)(i)(IV) or 1902(a)(10)(A)(ii)(IX) of the Act and loss of medically needy coverage described in section 1902(a)(10)(C) of the Act trigger a SEP for the individual losing such coverage. (For more information see 42 CFR 155.420(d)(1)(iii) and (iv) of the May 27, 2014 final rule.) Thus, if a woman is enrolled in Medicaid coverage for low-income pregnant women that is not recognized as MEC, she will be eligible for a SEP upon loss of such coverage. Similarly, an individual eligible for medically needy coverage that is not recognized as MEC is eligible for a SEP upon loss of such coverage, including at the end of a budget period when medically needy coverage

ends until the individual has met his or her spend down amount for the next budget period. Individuals are limited under the Marketplace regulations to one SEP based on loss of medically needy coverage per year.

We will work closely with each state in applying the standards established in this State Health Official Letter to the coverage for low-income pregnant women, medically needy individuals, and individuals who are eligible for coverage under a section 1115 demonstration project, as applicable.

If you have any questions regarding this information, please contact Eliot Fishman, Director, Children and Adult Health Program Group, CMCS at 410-786-5647.

Sincerely,

/s/

Cindy Mann  
Director

cc:

CMS Regional Administrators  
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