

**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HUMAN SERVICES
APPEALS OFFICE
57 Howard Avenue
Cranston, Rhode Island 02920
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Docket # 14-1181
Hearing Date: September 24, 2014

Date: October 8, 2014

ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided against you. During the course of the proceeding, the following issue(s) and Agency policy reference(s) were the matters before the hearing:

Policy Manual: Executive Office of Health & Human Services: Medicaid Coverage under the Affordable Care Act § 1300.03 Applicability

RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH BENEFITS EXCHANGE, § 8.0 MINIMUM ESSENTIAL COVERAGE EXEMPTIONS

26 U.S.C. § 5000A. Requirement to maintain minimum essential coverage

The facts of your case, the Agency policy, and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page of this decision.

Copies of this decision have been sent to the following: You (the Appellant), Cheryl Dessaint Agency Supervisor/Representative and the Policy Unit.

Present at the hearing were: You (the Appellant), Cheryl Dessaint Agency Supervisor/Representative and Kathleen Morrison, Interpreter/Translator for the Appellant.

ISSUE: Was the Appellant properly denied benefits through HealthSource RI?

DHS POLICIES:

Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Department of Human Services Policy and Provider Manuals.

APPEAL RIGHTS:

Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

DISCUSSION OF THE EVIDENCE:

The Agency Representatives testified:

- The Appellant had applied for health care through HealthSource RI and on January 12, 2014 HealthSource requested more documentation due to some of the information on the application did not match HealthSource RI's records. HealthSource RI had proof of other insurance coverage that the Appellant had.
- HealthSource RI received documentation that the Appellant was enrolled in a Medicare plan.
- On January 16, 2014 HealthSource RI informed the Appellant that he was not eligible to purchase health insurance through HealthSource RI due to being enrolled in a Medicare plan and not eligible for Medicaid. (The Appellant was found to be over income for Medicaid but eligible for the Flex Plan portion, where he would have to pay for the first \$1,116.00 of his medical expenses and then be eligible for Medicaid)
- Policy is that an adult that does not have a child living in the home with them cannot be eligible for the affordable care act if they already have a reasonable and comparable insurance plan.
- On February 13, 2014 the Appellant filed an Appeal due to he is not able to afford to go to the doctors or pay for medication due to a lack of money, he only receives \$942.00 per month from social security and he has to pay rent, food to buy and utilities to pay for.
- Agency indicated that the Appellant is eligible for the Flex Plan for Medical Assistance, which would require the Appellant to pay the first \$1,116.00 for the period of May 1, 2014 through October 31, 2014 (six month) and then the State would pay any remaining medical expense for this six month time frame. Since this period of eligibility for the Flex Plan is almost over, the Appellant will need to re-apply for the next six month period by November 1, 2014.
- Also, the Appellant is eligible to have the State pay for his Medicare Premium.

The Appellant testified:

- The Appellant is on social security, he needs to pay rent, buy food and pay utilities and he cannot afford to pay to go to the doctors or to pay for medications. The Appellant only receives \$942.00 per month from social security.
- The Appellant needs to go to the dentist and the eye doctor but cannot afford to.

FINDINGS OF FACT:

- The Appellant applied for health care from HealthSource RI but was not found eligible due to having a Medicare plan through social security.
- Policy is that an adult that does not have a child living in the home with them cannot be eligible for the affordable care act if they already have a reasonable and comparable insurance plan.
- After receiving a notice of denial, the Appellant Appealed due to he is not able to afford to go to the doctors or pay for medications due to a lack of money, he only receives \$942.00 per month from social security and he has to pay rent, food to buy and utilities.

CONCLUSION:

The issue to be decided is whether the Appellant was properly denied benefits through HealthSource RI.

The Appellant receives \$942.00 per month from social security disability and was seeking assistance with some of his medical expenses. During the open enrollment period, the Appellant applied for healthcare through HealthSource RI as part of the Affordable Care Act (ACA). As part of the application requirement, applicants must provide personable identifiable information for the purpose of creating an account. Once the identity has been verified, the agency must conduct account matches to determine whether the applicant or members of the applicant's household have other accounts or are currently receiving benefits. People that are found to have or can secure adequate healthcare coverage, minimum essential coverage (MEC), through another source other than HealthSource RI, are ineligible for the benefits through HealthSource RI.

As part of the Appellant's application process, he indicated that he receives Medicare as part of his social security disability benefit and did not list as having any children under the age of 19 years old living in his household. The Appellant has also attempted to receive Medicaid but because of his income, was only eligible for the Flex Plan that requires him to incur the first \$1116.00 of medical bills himself. Due to the Appellant having social security benefits (and Medicare), he was found to already have a minimum essential coverage (MEC) health plan in place and was not living with a child under the age of 19, therefore not eligible for a healthcare plan through HealthSource RI.

1300.03 Applicability

REV: June 2014

Effective January 1, 2014, the rules in this chapter govern Medicaid eligibility for all NEW applicants subject to the MAGI standard in the following Medicaid Affordable Care Coverage (MACC) groups:

(01) Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) – Includes families and parents/caretakers

who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in

school full-time. It also includes families eligible for time-limited transitional Medicaid.

(02) Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.

(03) Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.

(04) Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified noncitizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

Individuals and families eligible to receive Medicaid in these coverage groups are subject to the MAGI standard for determining income eligibility beginning January 1, 2014 and, if eligible, at annual renewals thereafter.

Excluded Medicaid-eligible Coverage Groups

The rules in this chapter do not apply to:

- ACA Exemption – The ACA excludes certain Medicaid coverage groups from MAGI-based eligibility determinations. These groups are referred to as “Non-MAGI Coverage Groups” throughout this chapter. The ACA exemption applies to persons who are aged, blind, or with disabilities and eligible under MCAR sections 0582 or in need of long-term services and supports (LTSS) under the eligibility requirements in MCAR 0376. *The exemption also extends to individuals who qualify for Medicaid based on their eligibility for another publicly funded program, such as children in foster care and anyone receiving Supplemental Security Income (SSI) or*

participating in the Medicare Premium Payment Program. (emphasis added)

Special Provisions

MCAR section 1315 applies exclusively to parents/caretakers with income between 133% and 175 % of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended). All other rules in this chapter do not apply.

The goal of the Affordable Care Act is to improve access to high quality healthcare coverage for people of all ages and income levels. To accomplish this, the ACA requires that individuals have minimum essential coverage (MEC) each month or make a shared responsibility payment or fee when they file their federal income tax return after the end of the year.

26 U.S.C. § 5000A. Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage

An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

Furthermore, 26 U.S.C. § 5000A also provides a list of what/who is considered as having a MEC, exempting those with MEC from having to file an application for healthcare coverage.

26 U.S.C. § 5000A.

(f) Minimum essential coverage

For purposes of this section—

(1) In general

The term “minimum essential coverage” means any of the following:

(A) Government sponsored programs

Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act,

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

(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 Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

- (vii) the Non-appropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).
 - (B) Employer-sponsored plan
Coverage under an eligible employer-sponsored plan.
 - (C) Plans in the individual market
Coverage under a health plan offered in the individual market within a State.
 - (D) Grandfathered health plan
Coverage under a grandfathered health plan.
 - (E) Other coverage
Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.
- (2) Eligible employer-sponsored plan
The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—
- (A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or
 - (B) any other plan or coverage offered in the small or large group market within a State.
- Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.
- (3) Excepted benefits not treated as minimum essential coverage
The term "minimum essential coverage" shall not include health insurance coverage which consists of coverage of excepted benefits—
- (A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or
 - (B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.
- (4) Individuals residing outside United States or residents of territories
Any applicable individual shall be treated as having minimum essential coverage for any month—
- (A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or
 - (B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) Insurance-related terms

Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

The Appellant acknowledges having social security and Medicare which he stated in his HealthSource RI application and stated during his Hearing and HealthSource RI was able to confirm that the Appellant was receiving those benefits. The Appellant was just seeking some assistance with some of his medical expenses and was is hope that by filing an application with HealthSource RI, he would receive assistance. But in accordance with the rules and regulations stated above, the Appellant is already receiving assistance with healthcare coverage, unfortunately it the minimum essential coverage that is required.

After a careful review of the Agency's policies, as well as the evidence and testimony given, this Appeals Officer finds that the Appellant does not qualify for benefits through HealthSource RI. The appellant's request for relief is therefore denied.

A handwritten signature in black ink that reads "Thomas Bucacci". The signature is written in a cursive, flowing style.

Thomas Bucacci
Appeals Officer

APPENDIX

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

1300.03 Applicability

REV: June 2014

Effective January 1, 2014, the rules in this chapter govern Medicaid eligibility for all NEW applicants subject to the MAGI standard in the following Medicaid Affordable Care Coverage (MACC) groups:

(01) Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.

(02) Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.

(03) Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.

(04) Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified noncitizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

Individuals and families eligible to receive Medicaid in these coverage groups are subject to the MAGI standard for determining income eligibility beginning January 1, 2014 and, if eligible, at annual renewals thereafter.

Excluded Medicaid-eligible Coverage Groups

The rules in this chapter to do not apply to:

- ACA Exemption – The ACA excludes certain Medicaid coverage groups from MAGI-based eligibility determinations. These groups are referred to as “Non-MAGI Coverage Groups” throughout this chapter. The ACA exemption applies to persons who are aged, blind, or with disabilities and eligible under MCAR sections 0582 or in need of long-term services and supports (LTSS) under the eligibility requirements in MCAR 0376. The exemption also extends to individuals who qualify for Medicaid based on their eligibility for another publicly funded program, such as children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Payment Program.

Special Provisions

MCAR section 1315 applies exclusively to parents/caretakers with income between 133% and 175 % of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended). All other rules in this chapter do not apply.

RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH BENEFITS EXCHANGE

SECTION 8.0 MINIMUM ESSENTIAL COVERAGE EXEMPTIONS

8.1 **In General.** Section 5000A of the Internal Revenue Code of 1986, as added by the ACA, requires that for each month during the taxable year, a non-exempt individual must have minimum essential coverage, as defined under the law, or pay a shared responsibility payment.

- (a) The Exchange is authorized to issue exemptions to the minimum essential coverage requirement.
- (b) The Exchange may rely on HHS for this purpose until the Exchange establishes the procedures necessary to make such a determination.
- (c) The Exchange call center and web site shall provide information to consumers regarding the exemption eligibility process.

8.2 **Exchange Exemption Eligibility Determination.** Any application for an exemption from the minimum essential coverage requirement submitted to the Exchange will be determined by the Exchange promptly and without undue delay.

- (a) To the extent applicable, the Exchange will use information already available to it, so as not to request duplicate information from the applicant.

- (b) An exemption applicant who has a Social Security number must provide such number.
- (c) An individual who is not seeking an exemption for himself or herself need not provide a Social Security number, except as required by 45 C.F.R. §155.610(e)(3).
- (d) Once the applicant's eligibility for an exemption is approved pursuant to exemption eligibility standards as defined in 45 C.F.R. §155.605, the Exchange will send the applicant a notice that will serve as the certificate of exemption. The notice will instruct the application to retain the certificate as proof of exemption. If the exemption is denied, the Exchange will send the applicant a notice containing instructions on how to appeal the denial.
- (e) If the Exchange determines the applicant eligible for an exemption, the Exchange will transmit to the Internal Revenue Service the individual's name, Social Security number, exemption certificate number, and any other information required by the Internal Revenue Service.
- (f) The Exchange will attempt to verify information provided by the applicant in compliance with the requirements of 45 C.F.R. §155.615.

26 U.S.C. § 5000A. Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage

An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) Shared responsibility payment

(1) In general

If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) Inclusion with return

Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) Payment of penalty

If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) Amount of penalty

(1) In general

The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) Monthly penalty amounts

For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) Flat dollar amount

An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income

An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) 2.5 percent for taxable years beginning after 2015.

(3) Applicable dollar amount

For purposes of paragraph (1)—

(A) In general

Except as provided in subparagraphs (B) and (C), the applicable dollar amount is \$695.

(B) Phase in

The applicable dollar amount is \$95 for 2014 and \$325 for 2015.

(C) Special rule for individuals under age 18

If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(D) Indexing of amount

In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to \$695, increased by an amount equal to—

- (i) \$695, multiplied by
- (ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting “calendar year 2015” for “calendar year 1992” in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(4) Terms relating to income and families

For purposes of this section—

(A) Family size

The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income

The term “household income” means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

- (i) the modified adjusted gross income of the taxpayer, plus
- (ii) the aggregate modified adjusted gross incomes of all other individuals who—
 - (I) were taken into account in determining the taxpayer's family size under paragraph (1), and
 - (II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) Modified adjusted gross income

The term “modified adjusted gross income” means adjusted gross income increased by—

- (i) any amount excluded from gross income under section 911, and
- (ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

(d) Applicable individual

For purposes of this section—

(1) In general

The term “applicable individual” means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) Religious exemptions

(A) Religious conscience exemption

Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

- (i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and
- (ii) an adherent of established tenets or teachings of such sect or division as described in such section.

(B) Health care sharing ministry

(i) In general

Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) Health care sharing ministry

The term "health care sharing ministry" means an organization—

- (I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),
- (II) 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 regard to the State in which a member resides or is employed,
- (III) members of which retain membership even after they develop a medical condition,
- (IV) 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
- (V) 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.

(3) Individuals not lawfully present

Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) Incarcerated individuals

Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) Exemptions

No penalty shall be imposed under subsection (a) with respect to—

(1) Individuals who cannot afford coverage

(A) In general

Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the

taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) Required contribution

For purposes of this paragraph, the term "required contribution" means—

- (i) in the case of an individual eligible to purchase minimum essential coverage 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
- (ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), 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 under section 36B 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).

(C) Special rules for individuals related to employees

For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to 1 required contribution of the employee.

(D) Indexing

In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for "8 percent" the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) Taxpayers with income below filing threshold

Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) Members of Indian tribes

Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) Months during short coverage gaps

(A) In general

Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) Special rules

For purposes of applying this paragraph—

- (i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,
- (ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and
- (iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) Hardships

Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) Minimum essential coverage

For purposes of this section—

(1) In general

The term “minimum essential coverage” means any of the following:

(A) Government sponsored programs

Coverage under—

- (i) the Medicare program under part A of title XVIII of the Social Security Act,
- (ii) the Medicaid program under title XIX of the Social Security Act,
- (iii) the CHIP program under title XXI of the Social Security Act,
- (iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;
- (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 Health and Human Services and the Secretary,
- (vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or
- (vii) the Non-appropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National

Defense Authorization Act for Fiscal Year 1995 (Public Law 103–337; 10 U.S.C. 1587 note).

- (B) Employer-sponsored plan
Coverage under an eligible employer-sponsored plan.
- (C) Plans in the individual market
Coverage under a health plan offered in the individual market within a State.
- (D) Grandfathered health plan
Coverage under a grandfathered health plan.
- (E) Other coverage
Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) Eligible employer-sponsored plan

The term “eligible employer-sponsored plan” means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

- (A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or
- (B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) Excepted benefits not treated as minimum essential coverage

The term “minimum essential coverage” shall not include health insurance coverage which consists of coverage of excepted benefits—

- (A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or
- (B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) Individuals residing outside United States or residents of territories
Any applicable individual shall be treated as having minimum essential coverage for any month—

- (A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or
- (B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) Insurance-related terms

Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) Administration and procedure

(1) In general

The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) Special rules

Notwithstanding any other provision of law—

(A) Waiver of criminal penalties

In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) Limitations on liens and levies

The Secretary shall not—

- (i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or
- (ii) levy on any such property with respect to such failure.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.