

AmeriCorps State and National Member Health Care Q & A

General

Q1: Previously CNCS shared that they will not be changing the FY 2014 grant provisions with respect to the healthcare grantees are required to offer their members. Does this mean that we need to offer our members a different plan that's compliant with Minimum Essential Coverage (MEC) as detailed in the Affordable Care Act (ACA), or do our members need to seek alternative coverage through the exchanges or other options to avoid the individual shared responsibility payment (ISRP)?

A: Programs may satisfy their obligation to provide health insurance to full-time AmeriCorps members either by providing an insurance plan that meets the requirements detailed in the AmeriCorps grant provisions, by ensuring that members have insurance through the Health Insurance Marketplace or by purchasing MEC directly through an insurance carrier or broker. Programs should provide to members information about all options available (staying on parent's health insurance plan; purchase coverage through the health insurance marketplace; enroll in Medicaid; or continue to use the current health plan with the understanding that members may be assessed an individual shared responsibility payment if the coverage does not meet the requirements of ACA). It is important to explore all of these options with members.

Q2: May I purchase health insurance through the carrier that provides insurance to staff at my organization?

A: Yes, provided you clarify with your insurance carrier that members are not employees of your organization.

Q3: Our insurance carrier continues to claim that members are considered employees because they receive a W-2. Can you provide clarification on this point and perhaps point to any documents/statutes/regulations that state this for us to provide to our insurance carrier?

A: AmeriCorps members are not employees of the AmeriCorps program or of the federal government. The definition of "participant" in the National and Community Service Act includes AmeriCorps members. Under the law, "a participant (member) shall not be considered to be an employee of the organization receiving assistance under the national service laws through which the participant (member) is engaged in service" (42 U.S.C. 12511(30) (B)). Moreover, members are not allowed to perform an employee's duties or otherwise displace employees.

Q4: How do I know specifically if the AmeriCorps health insurance we offer our members meets the Minimum Essential Coverage standards of the ACA or not?

A: Questions about the details of your insurance plan should be directed to your insurance provider. They will be able to articulate whether or not the plan you have selected for your members is considered Minimum Essential Coverage (MEC).

Q5: Now that the ACA requires all Americans to have health insurance, does that change the requirement that AmeriCorps programs offer health insurance to its full-time members?

A: No. Grantees must still provide or make available healthcare to those members serving a 1700-hour full-time term who are not otherwise covered by an insurance policy at the time the member begins his/her term of service. The grantee must also provide or make available healthcare to members serving a 1700-hour full-time term who lose other coverage during their term of service as a result of service or through no deliberate act of their own.

Q6: For programs about to launch recruitment campaigns, what is the best language to use with AmeriCorps applicants about the healthcare benefits provided by AmeriCorps?

A: Programs may refer to the language provided in the letter distributed to members on December 16th (also found at: <http://www.nationalservice.gov/programs/americorps/current-members/health-care-options>). .

Q7: Do we know if the “hardship exemption” will apply to current AmeriCorps members whose plans were cancelled? If so, can we anticipate guidance on this new exemption and what it may mean for AmeriCorps members?

A: Members who do not have coverage that meets the Minimal Essential Coverage (MEC) standards of the ACA may be subject to a tax payment under the individual shared responsibility provision; however, the Department of Health and Human Services has exercised its authority to establish an additional hardship exemption for national service members who do not have coverage that meets the minimum essential coverage (MEC) requirements in the calendar year 2014 only. For more information on the guidance regarding the additional hardship exemption, please see (insert HHS website link here).

To request the hardship exemption, members may use the hardship exemption form available at <http://www.healthcare.gov/exemptions> and select reason #14. When prompted, members should fill in “AMERICORPS” as the reason. Please note - the Federal healthcare marketplace does not process hardship exemptions for the State of Connecticut. Members who are residents of Connecticut need to contact Access Health CT to apply for the hardship exemption.

Members may also qualify for an exemption from coverage for different reasons. For example, members may be exempt if they do not have to file a tax return because their income is too low or if they are affected by your state’s decision not to expand Medicaid coverage under the health care law.

For a complete list of exemptions and information on how to apply, please visit:

<https://www.healthcare.gov/exemptions>.

Q8: Is enrollment in the state exchange based on the person’s residence? Does the member have to cancel their current AmeriCorps coverage to participate in the exchange? Does the member have to cancel their current AmeriCorps coverage to participate in the state’s expanded Medicaid program?

A: Yes, enrollment is based on state residency. Each state is unique and every exchange may be different. State law is the best guidance in your state and CNCS wants to be clear that each state

exchange will determine how it treats individuals with non-MEC health insurance plans. In addition, every state's eligibility for Medicaid is different. Again, state law is the best guidance for you to follow.

Health Insurance Marketplace

Q1: If a program chooses to provide health insurance through the Health Insurance Marketplace, does this fulfill their responsibility (under the AmeriCorps rules) to provide healthcare coverage to full-time members?

A: Yes. Programs may satisfy their obligation to provide health insurance to full-time AmeriCorps members either by providing an insurance plan that meets the requirements detailed in the AmeriCorps grant provisions, by ensuring that members have insurance through the Health Insurance Marketplace or by purchasing MEC directly through an insurance carrier or broker. Programs should provide to members all options available (staying on parent's health insurance plan; purchase coverage through the health insurance marketplace; enroll in Medicaid; or continue to use the current health plan with the understanding that members may be assessed an individual shared responsibility payment if the coverage does not meet the requirements of ACA). It is important to explore all of these options with members.

Q2: I am trying to shop for coverage on the federal exchange. I found that if I answer the question that my employer offers health insurance, I am informed that I am ineligible for ACA health care.

A: AmeriCorps members are not employees and therefore are not being offered employer-sponsored plans. In the exchange, members should select "I'm not eligible for insurance through my employer or a family member's employer".

Q3: How can AmeriCorps members enroll in Affordable Care Act coverage outside of established open enrollment periods?

A: The Department of Health and Human Services (HHS) issued guidance that created a special healthcare enrollment period for AmeriCorps members.

Starting Service: If you started your AmeriCorps service after the open enrollment period ended (March 31, 2014), you have 60 days from your service start date to sign-up for healthcare coverage through the federal healthcare marketplace.

Ending Service: At the conclusion of your service, you are able to purchase a qualified health plan from the federal healthcare marketplace outside of the annual open enrollment period. You have 60 days from your service end date to sign-up for healthcare coverage. For example, if you conclude your service this summer, you will now be able to purchase a qualified health plan at the conclusion of your service, rather than waiting until open enrollment season.

To apply for coverage under the Special Enrollment Period, contact the Marketplace call center at 1-800-318-2596.

Budget

Q1: If we offer members the option of buying insurance through the exchanges, are we required to cover the cost for ANY plan they choose or can we stipulate what type of plan we will cover (silver, gold, bronze, PPO, HMO etc.)?

A: Programs may decide what amount they are willing to reimburse members to cover the costs of insurance so long as the amount is sufficient to obtain insurance on the exchange and all members are offered the same amount of reimbursement. If a member elects coverage above what the program is offering, the additional cost is the member's responsibility.

Q2: Can we set limits on the amount we will reimburse members?

A: Programs may decide for what amount they are willing to reimburse members to cover the costs of insurance so long as the amount is sufficient to obtain insurance on the exchange and all members are offered the same amount of reimbursement. Programs must develop a policy for implementation of their health care policy

Q3: Are these reimbursements considered taxable income?

A: Yes, reimbursements for health insurance premiums are considered taxable income for the member, and programs must have a way to document such reimbursements.

Q4: Why are these reimbursements taxable?

A: The tax treatment of reimbursements for health insurance premiums is within the jurisdiction of the IRS.

Q5: Can you clarify if CNCS will allow us to consider it an allowable cost on the grant for AmeriCorps programs to reimburse members for the individual \$95 penalty/fine if they end up having to pay it because the program is unable to provide an ACA-compliant health care plan?

A: CNCS grant funds cannot be used to reimburse members for any individual shared responsibility payments (ISRP).

Q6. Can a program have a policy to pay full-time members a set amount for them to purchase insurance on the open market?

A: The key is for programs to provide equitable coverage. CNCS does not pre-define the meaning of "equitable" coverage; instead each program must have a policy that defines what they deem is equitable coverage for their members.

Q7: Can the program give the members the cost the program currently pays for insurance and allow the members to use that towards their insurance through the state exchange?

A; Programs must determine how equitable coverage will be provided to members.

Q8: How should a process for reimbursing members be structured? Can CNCS provide some guidance? For example, what sort of documentation would likely be recommended on the part of the program for this process?

A: Programs must develop a policy and process for implementation of their health care policy. The process, at a minimum, must require sufficient documentation (invoice, cancelled check, etc.) to

demonstrate that the member has health coverage. Please make sure to also follow applicable state laws and guidance on reimbursement procedures.

Q9: Can a member select a higher level coverage than the program offers? For example, they would like to purchase a silver level plan, but our program is offering bronze level coverage.

A: If a member elects coverage above what the program is offering, the additional cost is the member's responsibility.